

# Union Calendar No. 396

106<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 4680

**[Report No. 106–703, Part I]**

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 15, 2000

Mr. THOMAS (for himself, Mr. BURR of North Carolina, Mr. PETERSON of Minnesota, Mr. BLILEY, and Mr. HALL of Texas) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

JUNE 27, 2000

Reported from the Committee on Ways and Means with an amendment

[Strike out all after the enacting clause and insert the part printed in *italic*]

JUNE 27, 2000

Referral to the Committee on Commerce extended for a period ending not later than June 27, 2000

JUNE 27, 2000

Additional sponsors: Mr. KUYKENDALL, Mr. MARTINEZ, and Mr. ROGAN

JUNE 27, 2000

Committee on Commerce discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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# A BILL

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) *SHORT TITLE.*—*This Act may be cited as the*  
 5 *“Medicare Rx 2000 Act”.*

6 (b) *TABLE OF CONTENTS.*—*The table of contents of this*  
 7 *Act is as follows:*

*Sec. 1. Short title; table of contents.*

**TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT**

*Sec. 101. Establishment of a medicare prescription drug benefit.*

**“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM**

*“Sec. 1860A. Benefits; eligibility; enrollment; and coverage period.*

*“Sec. 1860B. Requirements for qualified prescription drug coverage.*

*“Sec. 1860C. Beneficiary protections for qualified prescription drug coverage.*

*“Sec. 1860D. Requirements for prescription drug plan (PDP) sponsors; contracts; establishment of standards.*

*“Sec. 1860E. Process for beneficiaries to select qualified prescription drug coverage.*

*“Sec. 1860F. Premiums.*

*“Sec. 1860G. Premium and cost-sharing subsidies for low-income individuals.*

*“Sec. 1860H. Subsidies for all medicare beneficiaries through reinsurance for qualified prescription drug coverage.*

*“Sec. 1860I. Medicare Prescription Drug Account in Federal Supplementary Medical Insurance Trust Fund.*

*“Sec. 1860J. Definitions; treatment of references to provisions in part C.”*

- Sec. 102. Offering of qualified prescription drug coverage under the Medicare+Choice program.*
- Sec. 103. Medicaid amendments.*
- Sec. 104. Medigap transition provisions.*
- Sec. 105. Demonstration project for disease management for severely chronically ill medicare beneficiaries.*

## **TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE**

### *Subtitle A—Medicare Benefits Administration*

- Sec. 201. Establishment of administration.*  
*“Sec. 1807. Medicare Benefits Administration.”*
- Sec. 202. Miscellaneous administrative provisions.*

### *Subtitle B—Oversight of Financial Sustainability of the Medicare Program*

- Sec. 211. Additional requirements for annual financial report and oversight on medicare program.*

### *Subtitle C—Changes in Medicare Coverage and Appeals Process*

- Sec. 221. Revisions to medicare appeals process.*
- Sec. 222. Provisions with respect to limitations on liability of beneficiaries.*
- Sec. 223. Waivers of liability for cost sharing amounts.*
- Sec. 224. Elimination of motions by the Secretary on decisions of the Provider Reimbursement Review Board.*

## **TITLE III—MEDICARE+CHOICE REFORMS; PRESERVATION OF MEDICARE PART B DRUG BENEFIT**

### *Subtitle A—Medicare+Choice Reforms*

- Sec. 301. Increase in national per capita Medicare+Choice growth percentage in 2001 and 2002.*
- Sec. 302. Permanently removing application of budget neutrality beginning in 2002.*
- Sec. 303. Increasing minimum payment amount.*
- Sec. 304. Allowing movement to 50:50 percent blend in 2002.*
- Sec. 305. Increased update for payment areas with only one or no Medicare+Choice contracts.*
- Sec. 306. Permitting higher negotiated rates in certain Medicare+Choice payment areas below national average.*
- Sec. 307. 10-year phase in of risk adjustment based on data from all settings.*

### *Subtitle B—Preservation of Medicare Coverage of Drugs and Biologicals*

- Sec. 311. Preservation of coverage of drugs and biologicals under part B of the medicare program.*
- Sec. 312. GAO report on part B payment for drugs and biologicals and related services.*

1                   ***TITLE I—MEDICARE***  
 2                   ***PRESCRIPTION DRUG BENEFIT***

3   ***SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION***  
 4                   ***DRUG BENEFIT.***

5           (a) *IN GENERAL.*—*Title XVIII of the Social Security*  
 6 *Act is amended—*

7                   (1) *by redesignating part D as part E; and*

8                   (2) *by inserting after part C the following new*  
 9           *part:*

10    “*PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT*  
 11   *PROGRAM*

12    “***SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND***  
 13                   ***COVERAGE PERIOD.***

14           “(a) *PROVISION OF QUALIFIED PRESCRIPTION DRUG*  
 15 *COVERAGE THROUGH ENROLLMENT IN PLANS.*—*Subject to*  
 16 *the succeeding provisions of this part, each individual who*  
 17 *is enrolled under part B is entitled to obtain qualified pre-*  
 18 *scription drug coverage (described in section 1860B(a)) as*  
 19 *follows:*

20                   “(1) *MEDICARE+CHOICE PLAN.*—*If the indi-*  
 21 *vidual is eligible to enroll in a Medicare+Choice plan*  
 22 *that provides qualified prescription drug coverage*  
 23 *under section 1851(j), the individual may enroll in*  
 24 *the plan and obtain coverage through such plan.*

1           “(2) *PRESCRIPTION DRUG PLAN.*—*If the indi-*  
 2           *vidual is not enrolled in a Medicare+Choice plan*  
 3           *that provides qualified prescription drug coverage, the*  
 4           *individual may enroll under this part in a prescrip-*  
 5           *tion drug plan (as defined in section 1860C(a)).*

6           *Such individuals shall have a choice of such plans under*  
 7           *section 1860E(d).*

8           “(b) *GENERAL ELECTION PROCEDURES.*—

9           “(1) *IN GENERAL.*—*An individual may elect to*  
 10          *enroll in a prescription drug plan under this part, or*  
 11          *elect the option of qualified prescription drug cov-*  
 12          *erage under a Medicare+Choice plan under part C,*  
 13          *and change such election only in such manner and*  
 14          *form as may be prescribed by regulations of the Ad-*  
 15          *ministrator of the Medicare Benefits Administration*  
 16          *(appointed under section 1807(b)) (in this part re-*  
 17          *ferred to as the ‘Medicare Benefits Administrator’)*  
 18          *and only during an election period prescribed in or*  
 19          *under this subsection.*

20          “(2) *ELECTION PERIODS.*—

21          “(A) *IN GENERAL.*—*Except as provided in*  
 22          *this paragraph, the election periods under this*  
 23          *subsection shall be the same as the coverage elec-*  
 24          *tion periods under the Medicare+Choice pro-*  
 25          *gram under section 1851(e), including—*

1                   “(i) *annual coordinated election peri-*  
2                   *ods; and*

3                   “(ii) *special election periods.*

4                   *In applying the last sentence of section*  
5                   *1851(e)(4) (relating to discontinuance of a*  
6                   *Medicare+Choice election during the first year*  
7                   *of eligibility) under this subparagraph, in the*  
8                   *case of an election described in such section in*  
9                   *which the individual had elected or is provided*  
10                  *qualified prescription drug coverage at the time*  
11                  *of such first enrollment, the individual shall be*  
12                  *permitted to enroll in a prescription drug plan*  
13                  *under this part at the time of the election of cov-*  
14                  *erage under the original fee-for-service plan.*

15                  “(B) *INITIAL ELECTION PERIODS.—*

16                  “(i) *INDIVIDUALS CURRENTLY COV-*  
17                  *ERED.—In the case of an individual who is*  
18                  *enrolled under part B as of November 1,*  
19                  *2002, there shall be an initial election pe-*  
20                  *riod of 6 months beginning on that date.*

21                  “(ii) *INDIVIDUAL COVERED IN FU-*  
22                  *TURE.—In the case of an individual who is*  
23                  *first enrolled under part B after November*  
24                  *1, 2002, there shall be an initial election pe-*

1                   riod which is the same as the initial enroll-  
 2                   ment period under section 1837(d).

3                   “(C) *ADDITIONAL SPECIAL ELECTION PERI-*  
 4                   *ODS.—The Medicare Benefits Administrator*  
 5                   *shall establish special election periods—*

6                   “(i) *in cases of individuals who have*  
 7                   *and involuntarily lose prescription drug*  
 8                   *coverage described in subsection (c)(2)(C);*

9                   “(ii) *in cases described in section*  
 10                  *1837(h) (relating to errors in enrollment),*  
 11                  *in the same manner as such section applies*  
 12                  *to part B; and*

13                  “(iii) *in the case of an individual who*  
 14                  *meets such exceptional conditions (including*  
 15                  *conditions recognized under section*  
 16                  *1851(d)(4)(D)) as the Administrator may*  
 17                  *provide.*

18                  “(D) *ONE-TIME ENROLLMENT PERMITTED*  
 19                  *FOR CURRENT PART A ONLY BENEFICIARIES.—In*  
 20                  *the case of an individual who as of November 1,*  
 21                  *2002—*

22                  “(i) *is entitled to benefits under part*  
 23                  *A; and*

24                  “(ii) *is not (and has not previously*  
 25                  *been) enrolled under part B;*

1        *the individual shall be eligible to enroll in a pre-*  
 2        *scription drug plan under this part but only*  
 3        *during the period described in subparagraph*  
 4        *(B)(i). If the individual enrolls in such a plan,*  
 5        *the individual may change such enrollment*  
 6        *under this part, but the individual may not en-*  
 7        *roll in a Medicare+Choice plan under part C*  
 8        *unless the individual enrolls under part B. Noth-*  
 9        *ing in this subparagraph shall be construed as*  
 10       *providing for coverage under a prescription drug*  
 11       *plan of benefits that are excluded because of the*  
 12       *application of section 1860B(f)(2)(B).*

13       “(c) *GUARANTEED ISSUE; COMMUNITY RATING; AND*  
 14       *NONDISCRIMINATION.*—

15       “(1) *GUARANTEED ISSUE.*—

16       “(A) *IN GENERAL.*—*An eligible individual*  
 17       *who is eligible to elect qualified prescription*  
 18       *drug coverage under a prescription drug plan or*  
 19       *Medicare+Choice plan at a time during which*  
 20       *elections are accepted under this part with re-*  
 21       *spect to the plan shall not be denied enrollment*  
 22       *based on any health status-related factor (de-*  
 23       *scribed in section 2702(a)(1) of the Public*  
 24       *Health Service Act) or any other factor.*

1           “(B) *MEDICARE+CHOICE LIMITATIONS PER-*  
 2           *MITTED.—The provisions of paragraphs (2) and*  
 3           *(3) (other than subparagraph (C)(i), relating to*  
 4           *default enrollment) of section 1851(g) (relating*  
 5           *to priority and limitation on termination of*  
 6           *election) shall apply to PDP sponsors under this*  
 7           *subsection.*

8           “(2) *COMMUNITY-RATED PREMIUM.—*

9           “(A) *IN GENERAL.—In the case of an indi-*  
 10          *vidual who maintains (as determined under sub-*  
 11          *paragraph (C)) continuous prescription drug*  
 12          *coverage since first qualifying to elect prescrip-*  
 13          *tion drug coverage under this part, a PDP spon-*  
 14          *sor or Medicare+Choice organization offering a*  
 15          *prescription drug plan or Medicare+Choice plan*  
 16          *that provides qualified prescription drug cov-*  
 17          *erage and in which the individual is enrolled*  
 18          *may not deny, limit, or condition the coverage or*  
 19          *provision of covered prescription drug benefits or*  
 20          *increase the premium under the plan based on*  
 21          *any health status-related factor described in sec-*  
 22          *tion 2702(a)(1) of the Public Health Service Act*  
 23          *or any other factor.*

24          “(B) *LATE ENROLLMENT PENALTY.—In the*  
 25          *case of an individual who does not maintain*

1        *such continuous prescription drug coverage, a*  
 2        *PDP sponsor or Medicare+Choice organization*  
 3        *may (notwithstanding any provision in this*  
 4        *title) increase the premium otherwise applicable*  
 5        *or impose a pre-existing condition exclusion with*  
 6        *respect to qualified prescription drug coverage in*  
 7        *a manner that reflects additional actuarial risk*  
 8        *involved. Such a risk shall be established through*  
 9        *an appropriate actuarial opinion of the type de-*  
 10       *scribed in subparagraphs (A) through (C) of sec-*  
 11       *tion 2103(c)(4).*

12            “(C) CONTINUOUS PRESCRIPTION DRUG  
 13        *COVERAGE.—An individual is considered for*  
 14        *purposes of this part to be maintaining contin-*  
 15        *uous prescription drug coverage on and after a*  
 16        *date if the individual establishes that there is no*  
 17        *period of 63 days or longer on and after such*  
 18        *date (beginning not earlier than January 1,*  
 19        *2003) during all of which the individual did not*  
 20        *have any of the following prescription drug cov-*  
 21        *erage:*

22            “(i) COVERAGE UNDER PRESCRIPTION  
 23        *DRUG PLAN OR MEDICARE+CHOICE PLAN.—*  
 24        *Qualified prescription drug coverage under*

1           a prescription drug plan or under a  
2           Medicare+Choice plan.

3           “(ii) *MEDICAID PRESCRIPTION DRUG*  
4           *COVERAGE.*—Prescription drug coverage  
5           under a medicaid plan under title XIX, in-  
6           cluding through the Program of All-inclu-  
7           sive Care for the Elderly (PACE) under sec-  
8           tion 1934, through a social health mainte-  
9           nance organization (referred to in section  
10          4104(c) of the Balanced Budget Act of  
11          1997), or through a Medicare+Choice  
12          project that demonstrates the application of  
13          capitation payment rates for frail elderly  
14          medicare beneficiaries through the use of a  
15          interdisciplinary team and through the pro-  
16          vision of primary care services to such bene-  
17          ficiaries by means of such a team at the  
18          nursing facility involved.

19          “(iii) *PRESCRIPTION DRUG COVERAGE*  
20          *UNDER GROUP HEALTH PLAN.*—Any out-  
21          patient prescription drug coverage under a  
22          group health plan, including a health bene-  
23          fits plan under the Federal Employees  
24          Health Benefit Plan under chapter 89 of  
25          title 5, United States Code, and a qualified

1            *retiree prescription drug plan as defined in*  
 2            *section 1860H(f)(1).*

3            “(iv) *PRESCRIPTION DRUG COVERAGE*  
 4            *UNDER CERTAIN MEDIGAP POLICIES.*—Coverage under a medicare supplemental policy  
 5            *under section 1882 that provides benefits for*  
 6            *prescription drugs (whether or not such cov-*  
 7            *erage conforms to the standards for pack-*  
 8            *ages of benefits under section 1882(p)(1)),*  
 9            *but only if the policy was in effect on Janu-*  
 10           *ary 1, 2003, and only until the date such*  
 11           *coverage is terminated.*

12           “(v) *STATE PHARMACEUTICAL ASSIST-*  
 13           *ANCE PROGRAM.*—Coverage of prescription  
 14           *drugs under a State pharmaceutical assist-*  
 15           *ance program.*

16           “(vi) *VETERANS’ COVERAGE OF PRE-*  
 17           *SCRIPTION DRUGS.*—Coverage of prescrip-  
 18           *tion drugs for veterans under chapter 17 of*  
 19           *title 38, United States Code.*

20           “(D) *CERTIFICATION.*—For purposes of car-  
 21           *rying out this paragraph, the certifications of the*  
 22           *type described in sections 2701(e) of the Public*  
 23           *Health Service Act and in section 9801(e) of the*  
 24           *Internal Revenue Code shall also include a state-*  
 25

1           *ment for the period of coverage of whether the in-*  
 2           *dividual involved had prescription drug coverage*  
 3           *described in subparagraph (C).*

4           “(E) *CONSTRUCTION.*—*Nothing in this sec-*  
 5           *tion shall be construed as preventing the*  
 6           *disenrollment of an individual from a prescrip-*  
 7           *tion drug plan or a Medicare+Choice plan based*  
 8           *on the termination of an election described in*  
 9           *section 1851(g)(3), including for non-payment of*  
 10           *premiums or for other reasons specified in sub-*  
 11           *section (d)(3), which takes into account a grace*  
 12           *period described in section 1851(g)(3)(B)(i).*

13           “(3) *NONDISCRIMINATION.*—*A PDP sponsor of-*  
 14           *fering a prescription drug plan shall not establish a*  
 15           *service area in a manner that would discriminate*  
 16           *based on health or economic status of potential enroll-*  
 17           *ees.*

18           “(d) *EFFECTIVE DATE OF ELECTIONS.*—

19           “(1) *IN GENERAL.*—*Except as provided in this*  
 20           *section, the Medicare Benefits Administrator shall*  
 21           *provide that elections under subsection (b) take effect*  
 22           *at the same time as the Secretary provides that simi-*  
 23           *lar elections under section 1851(e) take effect under*  
 24           *section 1851(f).*

1           “(2) *NO ELECTION EFFECTIVE BEFORE 2003.*—In  
 2           *no case shall any election take effect before January*  
 3           *1, 2003.*

4           “(3) *TERMINATION.*—*The Medicare Benefits Ad-*  
 5           *ministrator shall provide for the termination of an*  
 6           *election in the case of—*

7                   “(A) *termination of coverage under part B*  
 8                   *(other than the case of an individual described*  
 9                   *in subsection (b)(2)(D) (relating to part A only*  
 10                   *individuals)); and*

11                   “(B) *termination of elections described in*  
 12                   *section 1851(g)(3) (including failure to pay re-*  
 13                   *quired premiums).*

14   **“SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIP-**  
 15                   **TION DRUG COVERAGE.**

16           “(a) *REQUIREMENTS.*—

17                   “(1) *IN GENERAL.*—*For purposes of this part*  
 18                   *and part C, the term ‘qualified prescription drug cov-*  
 19                   *erage’ means either of the following:*

20                           “(A) *STANDARD COVERAGE WITH ACCESS*  
 21                           *TO NEGOTIATED PRICES.*—*Standard coverage (as*  
 22                           *defined in subsection (b)) and access to nego-*  
 23                           *tiated prices under subsection (d).*

24                           “(B) *ACTUARIALLY EQUIVALENT COVERAGE*  
 25                           *WITH ACCESS TO NEGOTIATED PRICES.*—*Cov-*

1        *erage of covered outpatient drugs which meets the*  
2        *alternative coverage requirements of subsection*  
3        *(c) and access to negotiated prices under sub-*  
4        *section (d).*

5        *“(2) PERMITTING ADDITIONAL OUTPATIENT PRE-*  
6        *SCRIPTION DRUG COVERAGE.—*

7                *“(A) IN GENERAL.—Subject to subpara-*  
8        *graph (B), nothing in this part shall be con-*  
9        *strued as preventing qualified prescription drug*  
10       *coverage from including coverage of covered out-*  
11       *patient drugs that exceeds the coverage required*  
12       *under paragraph (1), but any such additional*  
13       *coverage shall be limited to coverage of covered*  
14       *outpatient drugs.*

15               *“(B) DISAPPROVAL AUTHORITY.—The Medi-*  
16       *care Benefits Administrator shall review the of-*  
17       *fering of qualified prescription drug coverage*  
18       *under this part or part C. If the Administrator*  
19       *finds that, in the case of a qualified prescription*  
20       *drug coverage under a prescription drug plan or*  
21       *a Medicare+Choice plan, that the organization*  
22       *or sponsor offering the coverage is purposefully*  
23       *engaged in activities intended to result in favor-*  
24       *able selection of those eligible medicare bene-*  
25       *ficiaries obtaining coverage through the plan, the*

1           Administrator may terminate the contract with  
 2           the sponsor or organization under this part or  
 3           part C.

4           “(3) *APPLICATION OF SECONDARY PAYOR PROVI-*  
 5           *SIONS.—The provisions of section 1852(a)(4) shall*  
 6           *apply under this part in the same manner as they*  
 7           *apply under part C.*

8           “(b) *STANDARD COVERAGE.—For purposes of this*  
 9           *part, the ‘standard coverage’ is coverage of covered out-*  
 10           *patient drugs (as defined in subsection (f)) that meets the*  
 11           *following requirements:*

12           “(1) *DEDUCTIBLE.—The coverage has an annual*  
 13           *deductible—*

14           “(A) *for 2003, that is equal to \$250; or*

15           “(B) *for a subsequent year, that is equal to*  
 16           *the amount specified under this paragraph for*  
 17           *the previous year increased by the percentage*  
 18           *specified in paragraph (5) for the year involved.*

19           *Any amount determined under subparagraph (B)*  
 20           *that is not a multiple of \$5 shall be rounded to the*  
 21           *nearest multiple of \$5.*

22           “(2) *LIMITS ON COST-SHARING.—The coverage*  
 23           *has cost-sharing (for costs above the annual deductible*  
 24           *specified in paragraph (1) and up to the initial cov-*  
 25           *erage limit under paragraph (3)) that is equal to 50*

1     *percent or that is actuarially consistent (using proc-*  
 2     *esses established under subsection (e)) with an average*  
 3     *expected payment of 50 percent of such costs.*

4             “(3) *INITIAL COVERAGE LIMIT.*—Subject to para-  
 5     *graph (4), the coverage has an initial coverage limit*  
 6     *on the maximum costs that may be recognized for*  
 7     *payment purposes (above the annual deductible)—*

8                 “(A) *for 2003, that is equal to \$2,100; or*

9                 “(B) *for a subsequent year, that is equal to*  
 10     *the amount specified in this paragraph for the*  
 11     *previous year, increased by the annual percent-*  
 12     *age increase described in paragraph (5) for the*  
 13     *year involved.*

14     *Any amount determined under subparagraph (B)*  
 15     *that is not a multiple of \$25 shall be rounded to the*  
 16     *nearest multiple of \$25.*

17             “(4) *LIMITATION ON OUT-OF-POCKET EXPENDI-*  
 18     *TURES BY BENEFICIARY.*—

19                 “(A) *IN GENERAL.*—Notwithstanding para-  
 20     *graph (3), the coverage provides benefits without*  
 21     *any cost-sharing after the individual has in-*  
 22     *curring costs (as described in subparagraph (C))*  
 23     *for covered outpatient drugs in a year equal to*  
 24     *the annual out-of-pocket limit specified in sub-*  
 25     *paragraph (B).*

1           “(B) *ANNUAL OUT-OF-POCKET LIMIT.*—For  
2           purposes of this part, the ‘annual out-of-pocket  
3           limit’ specified in this subparagraph—

4                   “(i) for 2003, is equal to \$6,000; or

5                   “(ii) for a subsequent year, is equal to  
6                   the amount specified in this subparagraph  
7                   for the previous year, increased by the an-  
8                   nual percentage increase described in para-  
9                   graph (5) for the year involved.

10          Any amount determined under clause (ii) that is  
11          not a multiple of \$100 shall be rounded to the  
12          nearest multiple of \$100.

13           “(C) *APPLICATION.*—In applying subpara-  
14          graph (A)—

15                   “(i) incurred costs shall only include  
16                   costs incurred for the annual deductible (de-  
17                   scribed in paragraph (1)), cost-sharing (de-  
18                   scribed in paragraph (2)), and amounts for  
19                   which benefits are not provided because of  
20                   the application of the initial coverage limit  
21                   described in paragraph (3); and

22                   “(ii) such costs shall be treated as in-  
23                   curred without regard to whether the indi-  
24                   vidual or another person, including a State

1                    *program or other third-party coverage, has*  
 2                    *paid for such costs.*

3                    “(5) *ANNUAL PERCENTAGE INCREASE.—For pur-*  
 4                    *poses of this part, the annual percentage increase*  
 5                    *specified in this paragraph for a year is equal to the*  
 6                    *annual percentage increase in average per capita ag-*  
 7                    *gregate expenditures for covered outpatient drugs in*  
 8                    *the United States for medicare beneficiaries, as deter-*  
 9                    *mined by the Medicare Benefits Administrator for the*  
 10                    *12-month period ending in July of the previous year.*

11                    “(c) *ALTERNATIVE COVERAGE REQUIREMENTS.—A*  
 12                    *prescription drug plan or Medicare+Choice plan may pro-*  
 13                    *vide a different prescription drug benefit design from the*  
 14                    *standard coverage described in subsection (b) so long as the*  
 15                    *following requirements are met:*

16                    “(1) *ASSURING AT LEAST ACTUARIALLY EQUIVA-*  
 17                    *LENT COVERAGE.—*

18                    “(A) *ASSURING EQUIVALENT VALUE OF*  
 19                    *TOTAL COVERAGE.—The actuarial value of the*  
 20                    *total coverage (as determined under subsection*  
 21                    *(e)) is at least equal to the actuarial value (as*  
 22                    *so determined) of standard coverage.*

23                    “(B) *ASSURING EQUIVALENT UNSUBSIDIZED*  
 24                    *VALUE OF COVERAGE.—The unsubsidized value*  
 25                    *of the coverage is at least equal to the unsub-*

1        *sidized value of standard coverage. For purposes*  
 2        *of this subparagraph, the unsubsidized value of*  
 3        *coverage is the amount by which the actuarial*  
 4        *value of the coverage (as determined under sub-*  
 5        *section (e)) exceeds the actuarial value of the re-*  
 6        *insurance subsidy payments under section*  
 7        *1860H with respect to such coverage.*

8                *“(C) ASSURING STANDARD PAYMENT FOR*  
 9        *COSTS AT INITIAL COVERAGE LIMIT.—The cov-*  
 10        *erage is designed, based upon an actuarially rep-*  
 11        *resentative pattern of utilization (as determined*  
 12        *under subsection (e)), to provide for the pay-*  
 13        *ment, with respect to costs incurred that are*  
 14        *equal to the sum of the deductible under sub-*  
 15        *section (b)(1) and the initial coverage limit*  
 16        *under subsection (b)(3), of an amount equal to at*  
 17        *least such initial coverage limit multiplied by*  
 18        *the percentage specified in subsection (b)(2).*

19                *“(2) LIMITATION ON OUT-OF-POCKET EXPENDI-*  
 20        *TURES BY BENEFICIARIES.—The coverage provides the*  
 21        *limitation on out-of-pocket expenditures by bene-*  
 22        *ficiaries described in subsection (b)(4).*

23                *“(d) ACCESS TO NEGOTIATED PRICES.—Under quali-*  
 24        *fied prescription drug coverage offered by a PDP sponsor*  
 25        *or a Medicare+Choice organization, the sponsor or organi-*

1 zation shall provide beneficiaries with access to negotiated  
 2 prices (including applicable discounts) used for payment  
 3 for covered outpatient drugs, regardless of the fact that no  
 4 benefits may be payable under the coverage with respect to  
 5 such drugs because of the application of cost-sharing or an  
 6 initial coverage limit (described in subsection (b)(3)). Inso-  
 7 far as a State elects to provide medical assistance under  
 8 title XIX for a drug based on the prices negotiated by a  
 9 prescription drug plan under this part, the requirements  
 10 of section 1927 shall not apply to such drugs.

11 “(e) *ACTUARIAL VALUATION; DETERMINATION OF AN-*  
 12 *NUAL PERCENTAGE INCREASES.*—

13 “(1) *PROCESSES.*—For purposes of this section,  
 14 the Medicare Benefits Administrator shall establish  
 15 processes and methods—

16 “(A) for determining the actuarial valu-  
 17 ation of prescription drug coverage, including—

18 “(i) an actuarial valuation of standard  
 19 coverage and of the reinsurance subsidy  
 20 payments under section 1860H;

21 “(ii) the use of generally accepted actu-  
 22 arial principles and methodologies; and

23 “(iii) applying the same methodology  
 24 for determinations of alternative coverage  
 25 under subsection (c) as is used with respect

1                   to determinations of standard coverage  
2                   under subsection (b); and

3                   “(B) for determining annual percentage in-  
4                   creases described in subsection (b)(5).

5                   “(2) *USE OF OUTSIDE ACTUARIES.*—Under the  
6                   processes under paragraph (1)(A), PDP sponsors and  
7                   Medicare+Choice organizations may use actuarial  
8                   opinions certified by independent, qualified actuaries  
9                   to establish actuarial values.

10                  “(f) *COVERED OUTPATIENT DRUGS DEFINED.*—

11                   “(1) *IN GENERAL.*—Except as provided in this  
12                   subsection, for purposes of this part, the term ‘covered  
13                   outpatient drug’ means—

14                   “(A) a drug that may be dispensed only  
15                   upon a prescription and that is described in sub-  
16                   paragraph (A)(i) or (A)(ii) of section 1927(k)(2);  
17                   or

18                   “(B) a biological product or insulin de-  
19                   scribed in subparagraph (B) or (C) of such sec-  
20                   tion;

21                   and such term includes any use of a covered out-  
22                   patient drug for a medically accepted indication (as  
23                   defined in section 1927(k)(6)).

24                   “(2) *EXCLUSIONS.*—

1           “(A) *IN GENERAL.*—Such term does not in-  
 2           clude drugs or classes of drugs, or their medical  
 3           uses, which may be excluded from coverage or  
 4           otherwise restricted under section 1927(d)(2),  
 5           other than subparagraph (E) thereof (relating to  
 6           smoking cessation agents).

7           “(B) *AVOIDANCE OF DUPLICATE COV-*  
 8           *ERAGE.*—A drug prescribed for an individual  
 9           that would otherwise be a covered outpatient  
 10          drug under this part shall not be so considered  
 11          if payment for such drug is available under part  
 12          A or B (but shall be so considered if such pay-  
 13          ment is not available because benefits under part  
 14          A or B have been exhausted), without regard to  
 15          whether the individual is entitled to benefits  
 16          under part A or enrolled under part B.

17          “(3) *APPLICATION OF FORMULARY RESTRIC-*  
 18          *TIONS.*—A drug prescribed for an individual that  
 19          would otherwise be a covered outpatient drug under  
 20          this part shall not be so considered under a plan if  
 21          the plan excludes the drug under a formulary that  
 22          meets the requirements of section 1860C(f)(2) (includ-  
 23          ing providing an appeal process).

24          “(4) *APPLICATION OF GENERAL EXCLUSION PRO-*  
 25          *VISIONS.*—A prescription drug plan or

1     *Medicare+Choice plan may exclude from qualified*  
 2     *prescription drug coverage any covered outpatient*  
 3     *drug—*

4             *“(A) for which payment would not be made*  
 5             *if section 1862(a) applied to part D; or*

6             *“(B) which are not prescribed in accordance*  
 7             *with the plan or this part.*

8     *Such exclusions are determinations subject to recon-*  
 9     *sideration and appeal pursuant to section 1860C(f).*

10            *“(5) STUDY ON INCLUSION OF DRUGS TREATING*  
 11     *MORBID OBESITY.—The Medicare Policy Advisory*  
 12     *Board shall provide for a study on removing the ex-*  
 13     *clusion under paragraph (2)(A) for coverage of agents*  
 14     *used for weight loss in the case of morbidly obese in-*  
 15     *dividuals. The Board shall report to Congress on the*  
 16     *results of the study not later than March 1, 2002.*

17     **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED**  
 18             **PRESCRIPTION DRUG COVERAGE.**

19            *“(a) GUARANTEED ISSUE COMMUNITY-RELATED PRE-*  
 20     *MIUMS AND NONDISCRIMINATION.—For provisions requir-*  
 21     *ing guaranteed issue, community-rated premiums, and*  
 22     *nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2),*  
 23     *and 1860F(b).*

24            *“(b) DISSEMINATION OF INFORMATION.—*

1           “(1) *GENERAL INFORMATION.*—A PDP sponsor  
2       shall disclose, in a clear, accurate, and standardized  
3       form to each enrollee with a prescription drug plan  
4       offered by the sponsor under this part at the time of  
5       enrollment and at least annually thereafter, the infor-  
6       mation described in section 1852(c)(1) relating to  
7       such plan. Such information includes the following:

8           “(A) *Access to covered outpatient drugs, in-*  
9       *cluding access through pharmacy networks.*

10          “(B) *How any formulary used by the spon-*  
11       *sor functions.*

12          “(C) *Co-payments and deductible require-*  
13       *ments.*

14          “(D) *Grievance and appeals procedures.*

15          “(2) *DISCLOSURE UPON REQUEST OF GENERAL*  
16       *COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-*  
17       *TION.*—Upon request of an individual eligible to en-  
18       roll under a prescription drug plan, the PDP sponsor  
19       shall provide the information described in section  
20       1852(c)(2) (other than subparagraph (D)) to such in-  
21       dividual.

22          “(3) *RESPONSE TO BENEFICIARY QUESTIONS.*—  
23       Each PDP sponsor offering a prescription drug plan  
24       shall have a mechanism for providing specific infor-  
25       mation to enrollees upon request. The sponsor shall

1        *make available, through an Internet website and in*  
2        *writing upon request, information on specific changes*  
3        *in its formulary.*

4                “(4) *CLAIMS INFORMATION.—Each PDP sponsor*  
5        *offering a prescription drug plan must furnish to en-*  
6        *rolled individuals in a form easily understandable to*  
7        *such individuals an explanation of benefits (in ac-*  
8        *cordance with section 1806(a) or in a comparable*  
9        *manner) and a notice of the benefits in relation to*  
10       *initial coverage limit and annual out-of-pocket limit*  
11       *for the current year, whenever prescription drug bene-*  
12       *fits are provided under this part (except that such no-*  
13       *tice need not be provided more often than monthly).*

14                “(c) *ACCESS TO COVERED BENEFITS.—*

15                “(1) *ASSURING PHARMACY ACCESS.—The PDP*  
16        *sponsor of the prescription drug plan shall secure the*  
17        *participation of sufficient numbers of pharmacies*  
18        *(which may include mail order pharmacies) to ensure*  
19        *convenient access (including adequate emergency ac-*  
20        *cess) for enrolled beneficiaries, in accordance with*  
21        *standards established under section 1860D(e) that en-*  
22        *sure such convenient access. Nothing in this para-*  
23        *graph shall be construed as requiring the participa-*  
24        *tion of (or permitting the exclusion of) all pharmacies*  
25        *in any area under a plan.*

1           “(2) *ACCESS TO NEGOTIATED PRICES FOR PRE-*  
 2           *SCRIPTION DRUGS.*—*The PDP sponsor of a prescrip-*  
 3           *tion drug plan shall issue such a card that may be*  
 4           *used by an enrolled beneficiary to assure access to ne-*  
 5           *gotiated prices under section 1860B(d) for the pur-*  
 6           *chase of prescription drugs for which coverage is not*  
 7           *otherwise provided under the prescription drug plan.*

8           “(3) *REQUIREMENTS ON DEVELOPMENT AND AP-*  
 9           *PLICATION OF FORMULARIES.*—*Insofar as a PDP*  
 10          *sponsor of a prescription drug plan uses a formulary,*  
 11          *the following requirements must be met:*

12               “(A) *FORMULARY COMMITTEE.*—*The spon-*  
 13               *sor must establish a pharmaceutical and thera-*  
 14               *peutic committee that develops the formulary.*  
 15               *Such committee shall include at least one physi-*  
 16               *cian and at least one pharmacist.*

17               “(B) *INCLUSION OF DRUGS IN ALL THERA-*  
 18               *PEUTIC CATEGORIES.*—*The formulary must in-*  
 19               *clude drugs within all therapeutic categories and*  
 20               *classes of covered outpatient drugs (although not*  
 21               *necessarily for all drugs within such categories*  
 22               *and classes).*

23               “(C) *APPEALS AND EXCEPTIONS TO APPLI-*  
 24               *CATION.*—*The PDP sponsor must have, as part*  
 25               *of the appeals process under subsection (f)(2), a*

1           *process for appeals for denials of coverage based*  
 2           *on such application of the formulary.*

3           “(d) *COST AND UTILIZATION MANAGEMENT; QUALITY*  
 4 *ASSURANCE; MEDICATION THERAPY MANAGEMENT PRO-*  
 5 *GRAM.—*

6           “(1) *IN GENERAL.—The PDP sponsor shall have*  
 7           *in place—*

8                   “(A) *an effective cost and drug utilization*  
 9                   *management program, including appropriate in-*  
 10                   *centives to use generic drugs, when appropriate;*

11                   “(B) *quality assurance measures and sys-*  
 12                   *tems to reduce medical errors and adverse drug*  
 13                   *interactions, including a medication therapy*  
 14                   *management program described in paragraph*  
 15                   *(2); and*

16                   “(C) *a program to control fraud, abuse, and*  
 17                   *waste.*

18           “(2) *MEDICATION THERAPY MANAGEMENT PRO-*  
 19           *GRAM.—*

20                   “(A) *IN GENERAL.—A medication therapy*  
 21                   *management program described in this para-*  
 22                   *graph is a program of drug therapy management*  
 23                   *and medication administration that is designed*  
 24                   *to assure that covered outpatient drugs under the*  
 25                   *prescription drug plan are appropriately used to*

1       *achieve therapeutic goals and reduce the risk of*  
2       *adverse events, including adverse drug inter-*  
3       *actions.*

4               “(B) *ELEMENTS.—Such program may*  
5       *include—*

6                   “(i) *enhanced beneficiary under-*  
7       *standing of such appropriate use through*  
8       *beneficiary education, counseling, and other*  
9       *appropriate means; and*

10                  “(ii) *increased beneficiary adherence*  
11       *with prescription medication regimens*  
12       *through medication refill reminders, special*  
13       *packaging, and other appropriate means.*

14               “(C) *DEVELOPMENT OF PROGRAM IN CO-*  
15       *OPERATION WITH LICENSED PHARMACISTS.—The*  
16       *program shall be developed in cooperation with*  
17       *licensed pharmacists and physicians.*

18               “(D) *CONSIDERATIONS IN PHARMACY*  
19       *FEES.—The PDP sponsor of a prescription drug*  
20       *program shall take into account, in establishing*  
21       *fees for pharmacists and others providing serv-*  
22       *ices under the medication therapy management*  
23       *program, the resources and time used in imple-*  
24       *menting the program.*

1           “(3) *TREATMENT OF ACCREDITATION.*—Section  
 2           1852(e)(4) (relating to treatment of accreditation)  
 3           shall apply to prescription drug plans under this part  
 4           with respect to the following requirements, in the  
 5           same manner as they apply to Medicare+Choice  
 6           plans under part C with respect to the requirements  
 7           described in a clause of section 1852(e)(4)(B):

8                   “(A) Paragraph (1) (including quality as-  
 9                   surance), including medication therapy manage-  
 10                  ment program under paragraph (2).

11                  “(B) Subsection (c)(1) (relating to access to  
 12                  covered benefits).

13                  “(C) Subsection (g) (relating to confiden-  
 14                  tiality and accuracy of enrollee records).

15           “(4) *PUBLIC DISCLOSURE OF PHARMACEUTICAL*  
 16           *PRICES FOR GENERIC EQUIVALENT DRUGS.*—Each  
 17           PDP sponsor shall provide that each pharmacy or  
 18           other dispenser that arranges for the dispensing of a  
 19           covered outpatient drug shall inform the beneficiary  
 20           at the time of purchase of the drug of any differential  
 21           between the price of the prescribed drug to the enrollee  
 22           and the price of the lowest cost generic drug that is  
 23           therapeutically and pharmaceutically equivalent and  
 24           bioequivalent.

1       “(e) *GRIEVANCE MECHANISM.*—*Each PDP sponsor*  
 2 *shall provide meaningful procedures for hearing and resolv-*  
 3 *ing grievances between the organization (including any en-*  
 4 *tity or individual through which the sponsor provides cov-*  
 5 *ered benefits) and enrollees with prescription drug plans of*  
 6 *the sponsor under this part in accordance with section*  
 7 *1852(f).*

8       “(f) *COVERAGE DETERMINATIONS, RECONSIDER-*  
 9 *ATIONS, AND APPEALS.*—

10           “(1) *IN GENERAL.*—*A PDP sponsor shall meet*  
 11 *the requirements of section 1852(g) with respect to*  
 12 *covered benefits under the prescription drug plan it*  
 13 *offers under this part in the same manner as such re-*  
 14 *quirements apply to a Medicare+Choice organization*  
 15 *with respect to benefits it offers under a*  
 16 *Medicare+Choice plan under part C.*

17           “(2) *APPEALS OF FORMULARY DETERMINA-*  
 18 *TIONS.*—*Under the appeals process under paragraph*  
 19 *(1) an individual who is enrolled in a prescription*  
 20 *drug plan offered by a PDP sponsor may appeal to*  
 21 *obtain coverage for a covered outpatient drug that is*  
 22 *not on the formulary of the sponsor (established under*  
 23 *subsection (c)) if the prescribing physician determines*  
 24 *that the therapeutically similar drug that is on the*

1        *formulary is not as effective for the enrollee or has*  
 2        *significant adverse effects for the enrollee.*

3        “(g) *CONFIDENTIALITY AND ACCURACY OF ENROLLEE*  
 4        *RECORDS.*—A PDP sponsor shall meet the requirements of  
 5        *section 1852(h) with respect to enrollees under this part in*  
 6        *the same manner as such requirements apply to a*  
 7        *Medicare+Choice organization with respect to enrollees*  
 8        *under part C.*

9        “**SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**  
 10                    **PLAN (PDP) SPONSORS; CONTRACTS; ESTAB-**  
 11                    **LISHMENT OF STANDARDS.**

12        “(a) *GENERAL REQUIREMENTS.*—Each PDP sponsor  
 13        *of a prescription drug plan shall meet the following require-*  
 14        *ments:*

15                    “(1) *LICENSURE.*—Subject to subsection (c), the  
 16        *sponsor is organized and licensed under State law as*  
 17        *a risk-bearing entity eligible to offer health insurance*  
 18        *or health benefits coverage in each State in which it*  
 19        *offers a prescription drug plan.*

20                    “(2) *ASSUMPTION OF FULL FINANCIAL RISK.*—

21                    “(A) *IN GENERAL.*—Subject to subpara-  
 22        *graph (B) and section 1860E(d)(2), the entity*  
 23        *assumes full financial risk on a prospective basis*  
 24        *for qualified prescription drug coverage that it*  
 25        *offers under a prescription drug plan and that*

1           *is not covered under reinsurance under section*  
 2           *1860H.*

3           “(B) *REINSURANCE PERMITTED.*—*The enti-*  
 4           *ty may obtain insurance or make other arrange-*  
 5           *ments for the cost of coverage provided to any*  
 6           *enrolled member under this part.*

7           “(3) *SOLVENCY FOR UNLICENSED SPONSORS.*—*In*  
 8           *the case of a sponsor that is not described in para-*  
 9           *graph (1), the sponsor shall meet solvency standards*  
 10          *established by the Medicare Benefits Administrator*  
 11          *under subsection (d).*

12          “(b) *CONTRACT REQUIREMENTS.*—

13               “(1) *IN GENERAL.*—*The Medicare Benefits Ad-*  
 14               *ministrator shall not permit the election under section*  
 15               *1860A of a prescription drug plan offered by a PDP*  
 16               *sponsor under this part, and the sponsor shall not be*  
 17               *eligible for payments under section 1860G or 1860H,*  
 18               *unless the Administrator has entered into a contract*  
 19               *under this subsection with the sponsor with respect to*  
 20               *the offering of such plan. Such a contract with a*  
 21               *sponsor may cover more than 1 prescription drug*  
 22               *plan. Such contract shall provide that the sponsor*  
 23               *agrees to comply with the applicable requirements*  
 24               *and standards of this part and the terms and condi-*  
 25               *tions of payment as provided for in this part.*

1           “(2) *NEGOTIATION REGARDING TERMS AND CON-*  
2           *DITIONS.—The Medicare Benefits Administrator shall*  
3           *have the same authority to negotiate the terms and*  
4           *conditions of prescription drug plans under this part*  
5           *as the Director of the Office of Personnel Management*  
6           *has with respect to health benefits plans under chap-*  
7           *ter 89 of title 5, United States Code. In negotiating*  
8           *the terms and conditions regarding premiums for*  
9           *which information is submitted under section*  
10          *1860F(a)(2), the Administrator shall take into ac-*  
11          *count the reinsurance subsidy payments under section*  
12          *1860H and the adjusted community rate (as defined*  
13          *in section 1854(f)(3)) for the benefits covered.*

14          “(3)       *INCORPORATION       OF       CERTAIN*  
15          *MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The*  
16          *following provisions of section 1857 shall apply, sub-*  
17          *ject to subsection (c)(5), to contracts under this sec-*  
18          *tion in the same manner as they apply to contracts*  
19          *under section 1857(a):*

20               “(A) *MINIMUM ENROLLMENT.—Paragraphs*  
21               *(1) and (3) of section 1857(b).*

22               “(B) *CONTRACT PERIOD AND EFFECTIVE-*  
23               *NESS.—Paragraphs (1) through (3) and (5) of*  
24               *section 1857(c).*

1                   “(C) *PROTECTIONS AGAINST FRAUD AND*  
2                   *BENEFICIARY PROTECTIONS.—Section 1857(d).*

3                   “(D) *ADDITIONAL CONTRACT TERMS.—Sec-*  
4                   *tion 1857(e); except that in applying section*  
5                   *1857(e)(2) under this part—*

6                   “(i) *such section shall be applied sepa-*  
7                   *rately to costs relating to this part (from*  
8                   *costs under part C);*

9                   “(ii) *in no case shall the amount of the*  
10                  *fee established under this subparagraph for*  
11                  *a plan exceed 20 percent of the maximum*  
12                  *amount of the fee that may be established*  
13                  *under subparagraph (B) of such section;*  
14                  *and*

15                  “(iii) *no fees shall be applied under*  
16                  *this subparagraph with respect to*  
17                  *Medicare+Choice plans.*

18                  “(E) *INTERMEDIATE SANCTIONS.—Section*  
19                  *1857(g).*

20                  “(F) *PROCEDURES FOR TERMINATION.—*  
21                  *Section 1857(h).*

22                  “(4) *RULES OF APPLICATION FOR INTERMEDIATE*  
23                  *SANCTIONS.—In applying paragraph (3)(E)—*

1           “(A) the reference in section 1857(g)(1)(B)  
 2           to section 1854 is deemed a reference to this  
 3           part; and

4           “(B) the reference in section 1857(g)(1)(F)  
 5           to section 1852(k)(2)(A)(ii) shall not be applied.

6           “(c) *WAIVER OF CERTAIN REQUIREMENTS TO EXPAND*  
 7           *CHOICE.*—

8           “(1) *IN GENERAL.*—*In the case of an entity that*  
 9           *seeks to offer a prescription drug plan in a State, the*  
 10           *Medicare Benefits Administrator shall waive the re-*  
 11           *quirement of subsection (a)(1) that the entity be li-*  
 12           *censed in that State if the Administrator determines,*  
 13           *based on the application and other evidence presented*  
 14           *to the Administrator, that any of the grounds for ap-*  
 15           *proval of the application described in paragraph (2)*  
 16           *has been met.*

17           “(2) *GROUND FOR APPROVAL.*—*The grounds for*  
 18           *approval under this paragraph are the grounds for*  
 19           *approval described in subparagraph (B), (C), and*  
 20           *(D) of section 1855(a)(2), and also include the appli-*  
 21           *cation by a State of any grounds other than those re-*  
 22           *quired under Federal law.*

23           “(3) *APPLICATION OF WAIVER PROCEDURES.*—  
 24           *With respect to an application for a waiver (or a*  
 25           *waiver granted) under this subsection, the provisions*

1 of subparagraphs (E), (F), and (G) of section  
 2 1855(a)(2) shall apply.

3 “(4) *LICENSURE DOES NOT SUBSTITUTE FOR OR*  
 4 *CONSTITUTE CERTIFICATION.*—*The fact that an entity*  
 5 *is licensed in accordance with subsection (a)(1) does*  
 6 *not deem the entity to meet other requirements im-*  
 7 *posed under this part for a PDP sponsor.*

8 “(5) *REFERENCES TO CERTAIN PROVISIONS.*—  
 9 *For purposes of this subsection, in applying provi-*  
 10 *sions of section 1855(a)(2) under this subsection to*  
 11 *prescription drug plans and PDP sponsors—*

12 “(A) *any reference to a waiver application*  
 13 *under section 1855 shall be treated as a reference*  
 14 *to a waiver application under paragraph (1);*  
 15 *and*

16 “(B) *any reference to solvency standards*  
 17 *shall be treated as a reference to solvency stand-*  
 18 *ards established under subsection (d).*

19 “(d) *SOLVENCY STANDARDS FOR NON-LICENSED*  
 20 *SPONSORS.*—

21 “(1) *ESTABLISHMENT.*—*The Medicare Benefits*  
 22 *Administrator shall establish, by not later than Octo-*  
 23 *ber 1, 2001, financial solvency and capital adequacy*  
 24 *standards that an entity that does not meet the re-*

1        *quirements of subsection (a)(1) must meet to qualify*  
 2        *as a PDP sponsor under this part.*

3            “(2) *COMPLIANCE WITH STANDARDS.—Each*  
 4        *PDP sponsor that is not licensed by a State under*  
 5        *subsection (a)(1) and for which a waiver application*  
 6        *has been approved under subsection (c) shall meet sol-*  
 7        *vency and capital adequacy standards established*  
 8        *under paragraph (1). The Medicare Benefits Adminis-*  
 9        *trator shall establish certification procedures for such*  
 10       *PDP sponsors with respect to such solvency standards*  
 11       *in the manner described in section 1855(c)(2).*

12          “(e) *OTHER STANDARDS.—The Medicare Benefits Ad-*  
 13       *ministrator shall establish by regulation other standards*  
 14       *(not described in subsection (d)) for PDP sponsors and*  
 15       *plans consistent with, and to carry out, this part. The Ad-*  
 16       *ministrator shall publish such regulations by October 1,*  
 17       *2001. In order to carry out this requirement in a timely*  
 18       *manner, the Administrator may promulgate regulations*  
 19       *that take effect on an interim basis, after notice and pend-*  
 20       *ing opportunity for public comment.*

21          “(f) *RELATION TO STATE LAWS.—*

22            “(1) *IN GENERAL.—The standards established*  
 23       *under this section shall supersede any State law or*  
 24       *regulation (including standards described in para-*  
 25       *graph (2)) with respect to prescription drug plans*

1       *which are offered by PDP sponsors under this part to*  
 2       *the extent such law or regulation is inconsistent with*  
 3       *such standards.*

4               “(2) *STANDARDS SPECIFICALLY SUPERSEDED.—*  
 5       *State standards relating to the following are super-*  
 6       *seded under this subsection:*

7                       “(A) *Benefit requirements.*

8                       “(B) *Requirements relating to inclusion or*  
 9       *treatment of providers.*

10                      “(C) *Coverage determinations (including re-*  
 11       *lated appeals and grievance processes).*

12                      “(D) *Establishment and regulation of pre-*  
 13       *miums.*

14               “(3) *PROHIBITION OF STATE IMPOSITION OF*  
 15       *PREMIUM TAXES.—No State may impose a premium*  
 16       *tax or similar tax with respect to premiums paid to*  
 17       *PDP sponsors for prescription drug plans under this*  
 18       *part, or with respect to any payments made to such*  
 19       *a sponsor by the Medicare Benefits Administrator*  
 20       *under this part.*

21       **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**  
 22       **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

23               “(a) *IN GENERAL.—The Medicare Benefits Adminis-*  
 24       *trator, through the Office of Beneficiary Assistance, shall*  
 25       *establish, based upon and consistent with the procedures*

1 *used under part C (including section 1851), a process for*  
 2 *the selection of the prescription drug plan or*  
 3 *Medicare+Choice plan which offer qualified prescription*  
 4 *drug coverage through which eligible individuals elect quali-*  
 5 *fied prescription drug coverage under this part.*

6 “(b) *ELEMENTS.*—Such process shall include the fol-  
 7 *lowing:*

8 “(1) *Annual, coordinated election periods, in*  
 9 *which such individuals can change the qualifying*  
 10 *plans through which they obtain coverage, in accord-*  
 11 *ance with section 1860A(b)(2).*

12 “(2) *Active dissemination of information to pro-*  
 13 *mote an informed selection among qualifying plans*  
 14 *based upon price, quality, and other features, in the*  
 15 *manner described in (and in coordination with) sec-*  
 16 *tion 1851(d), including the provision of annual com-*  
 17 *parative information, maintenance of a toll-free hot-*  
 18 *line, and the use of non-federal entities.*

19 “(3) *Coordination of elections through filing*  
 20 *with a Medicare+Choice organization or a PDP*  
 21 *sponsor, in the manner described in (and in coordi-*  
 22 *nation with) section 1851(c)(2).*

23 “(c) *MEDICARE+CHOICE ENROLLEE IN PLAN OFFER-*  
 24 *ING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN*  
 25 *BENEFITS THROUGH THE PLAN.*—An individual who is

1 *enrolled under a Medicare+Choice plan that offers qualified*  
 2 *prescription drug coverage may only elect to receive quali-*  
 3 *fied prescription drug coverage under this part through*  
 4 *such plan.*

5 “(d) *ASSURING ACCESS TO A CHOICE OF QUALIFIED*  
 6 *PRESCRIPTION DRUG COVERAGE.*—

7 “(1) *CHOICE OF AT LEAST 2 PLANS IN EACH*  
 8 *AREA.*—

9 “(A) *IN GENERAL.*—*The Medicare Benefits*  
 10 *Administrator shall assure that each individual*  
 11 *who is enrolled under part B and who is resid-*  
 12 *ing in an area has available, consistent with*  
 13 *subparagraph (B), a choice of enrollment in at*  
 14 *least 2 qualifying plans (as defined in para-*  
 15 *graph (5)) in the area in which the individual*  
 16 *resides, at least one of which is a prescription*  
 17 *drug plan.*

18 “(B) *REQUIREMENT FOR DIFFERENT PLAN*  
 19 *SPONSORS.*—*The requirement in subparagraph*  
 20 *(A) is not satisfied with respect to an area if*  
 21 *only one PDP sponsor or Medicare+Choice orga-*  
 22 *nization offers all the qualifying plans in the*  
 23 *area.*

24 “(2) *GUARANTEEING ACCESS TO COVERAGE.*—*In*  
 25 *order to assure access under paragraph (1) and con-*

1        *sistent with paragraph (3), the Medicare Benefits Ad-*  
 2        *ministrator may provide financial incentives (includ-*  
 3        *ing partial underwriting of risk) for a PDP sponsor*  
 4        *to expand the service area under an existing prescrip-*  
 5        *tion drug plan to adjoining or additional areas or to*  
 6        *establish such a plan (including offering such a plan*  
 7        *on a regional or nationwide basis), but only so long*  
 8        *as (and to the extent) necessary to assure the access*  
 9        *guaranteed under paragraph (1).*

10        “(3) *LIMITATION ON AUTHORITY.—In exercising*  
 11        *authority under this subsection, the Medicare Benefits*  
 12        *Administrator—*

13                “(A) *shall not provide for the full under-*  
 14                *writing of financial risk for any PDP sponsor;*

15                “(B) *shall not provide for any underwriting*  
 16                *of financial risk for a public PDP sponsor with*  
 17                *respect to the offering of a nationwide prescrip-*  
 18                *tion drug plan; and*

19                “(C) *shall seek to maximize the assumption*  
 20                *of financial risk by PDP sponsors or*  
 21                *Medicare+Choice organizations.*

22        “(4) *REPORTS.—The Medicare Benefits Admin-*  
 23        *istrator shall, in each annual report to Congress*  
 24        *under section 1807(f), include information on the ex-*  
 25        *ercise of authority under this subsection. The Admin-*

1        *istrator also shall include such recommendations as*  
 2        *may be appropriate to minimize the exercise of such*  
 3        *authority, including minimizing the assumption of fi-*  
 4        *nancial risk.*

5                *“(5) QUALIFYING PLAN DEFINED.—For purposes*  
 6        *of this subsection, the term ‘qualifying plan’ means a*  
 7        *prescription drug plan or a Medicare+Choice plan*  
 8        *that includes qualified prescription drug coverage.*

9        **“SEC. 1860F. PREMIUMS.**

10        *“(a) SUBMISSION OF PREMIUMS AND RELATED INFOR-*  
 11        *MATION.—*

12                *“(1) IN GENERAL.—Each PDP sponsor shall*  
 13        *submit to the Medicare Benefits Administrator infor-*  
 14        *mation of the type described in paragraph (2) in the*  
 15        *same manner as information is submitted by a*  
 16        *Medicare+Choice organization under section*  
 17        *1854(a)(1).*

18                *“(2) TYPE OF INFORMATION.—The information*  
 19        *described in this paragraph is the following:*

20                        *“(A) Information on the qualified prescrip-*  
 21        *tion drug coverage to be provided.*

22                        *“(B) Information on the actuarial value of*  
 23        *the coverage.*

1           “(C) *Information on the monthly premium*  
 2           *to be charged for the coverage, including an actu-*  
 3           *arial certification of—*

4                     “(i) *the actuarial basis for such pre-*  
 5                     *mium;*

6                     “(ii) *the portion of such premium at-*  
 7                     *tributable to benefits in excess of standard*  
 8                     *coverage; and*

9                     “(iii) *the reduction in such premium*  
 10                    *resulting from the reinsurance subsidy pay-*  
 11                    *ments provided under section 1860H.*

12           “(D) *Such other information as the Medi-*  
 13           *care Benefits Administrator may require to*  
 14           *carry out this part.*

15           “(3) *REVIEW.—The Medicare Benefits Adminis-*  
 16           *trator shall review the information filed under para-*  
 17           *graph (2) for the purpose of conducting negotiations*  
 18           *under section 1860D(b)(2).*

19           “(b) *UNIFORM PREMIUM.—The premium for a pre-*  
 20           *scription drug plan charged under this section may not*  
 21           *vary among individuals enrolled in the plan in the same*  
 22           *service area, except as is permitted under section*  
 23           *1860A(c)(2)(B) (relating to late enrollment penalties).*

24           “(c) *TERMS AND CONDITIONS FOR IMPOSING PRE-*  
 25           *MIUMS.—The provisions of section 1854(d) shall apply*

1 *under this part in the same manner as they apply under*  
 2 *part C, and, for this purpose, the reference in such section*  
 3 *to section 1851(g)(3)(B)(i) is deemed a reference to section*  
 4 *1860A(d)(3)(B) (relating to failure to pay premiums re-*  
 5 *quired under this part).*

6 “(d) *ACCEPTANCE OF REFERENCE PREMIUM AS FULL*  
 7 *PREMIUM IF NO STANDARD (OR EQUIVALENT) COVERAGE*  
 8 *IN AN AREA.*—

9 “(1) *IN GENERAL.*—*If there is no standard pre-*  
 10 *scription drug coverage (as defined in paragraph (2))*  
 11 *offered in an area, in the case of an individual who*  
 12 *is eligible for a premium subsidy under section 1860G*  
 13 *and resides in the area, the PDP sponsor of any pre-*  
 14 *scription drug plan offered in the area (and any*  
 15 *Medicare+Choice organization that offers qualified*  
 16 *prescription drug coverage in the area) shall accept*  
 17 *the reference premium under section 1860G(b)(2) as*  
 18 *payment in full for the premium charge for qualified*  
 19 *prescription drug coverage.*

20 “(2) *STANDARD PRESCRIPTION DRUG COVERAGE*  
 21 *DEFINED.*—*For purposes of this subsection, the term*  
 22 *‘standard prescription drug coverage’ means qualified*  
 23 *prescription drug coverage that is standard coverage*  
 24 *or that has an actuarial value equivalent to the actu-*  
 25 *arial value for standard coverage.*

1 **“SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR**  
 2 **LOW-INCOME INDIVIDUALS.**

3 “(a) *IN GENERAL.*—

4 “(1) *FULL PREMIUM SUBSIDY AND REDUCTION*  
 5 *OF COST-SHARING FOR INDIVIDUALS WITH INCOME*  
 6 *BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.*—  
 7 *In the case of a subsidy eligible individual (as defined*  
 8 *in paragraph (3)) who is determined to have income*  
 9 *that does not exceed 135 percent of the Federal pov-*  
 10 *erty level, the individual is entitled under this*  
 11 *section—*

12 “(A) *to a premium subsidy equal to 100*  
 13 *percent of the amount described in subsection*  
 14 *(b)(1); and*

15 “(B) *subject to subsection (c), to the substi-*  
 16 *tution for the beneficiary cost-sharing described*  
 17 *in paragraphs (1) and (2) of section 1860B(b)*  
 18 *(up to the initial coverage limit specified in*  
 19 *paragraph (3) of such section) of amounts that*  
 20 *are nominal.*

21 “(2) *SLIDING SCALE PREMIUM SUBSIDY FOR IN-*  
 22 *DIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150*  
 23 *PERCENT, OF FEDERAL POVERTY LEVEL.*—*In the case*  
 24 *of a subsidy eligible individual who is determined to*  
 25 *have income that exceeds 135 percent, but does not ex-*  
 26 *ceed 150 percent, of the Federal poverty level, the in-*

1        *dividual is entitled under this section to a premium*  
 2        *subsidy determined on a linear sliding scale ranging*  
 3        *from 100 percent of the amount described in sub-*  
 4        *section (b)(1) for individuals with incomes at 135*  
 5        *percent of such level to 0 percent of such amount for*  
 6        *individuals with incomes at 150 percent of such level.*

7                “(3) *DETERMINATION OF ELIGIBILITY.*—

8                “(A) *SUBSIDY ELIGIBLE INDIVIDUAL DE-*  
 9        *FINED.*—*For purposes of this section, subject to*  
 10        *subparagraph (D), the term ‘subsidy eligible in-*  
 11        *dividual’ means an individual who—*

12                “(i) *is eligible to elect, and has elected,*  
 13        *to obtain qualified prescription drug cov-*  
 14        *erage under this part;*

15                “(ii) *has income below 150 percent of*  
 16        *the Federal poverty line; and*

17                “(iii) *meets the resources requirement*  
 18        *described in section 1905(p)(1)(C).*

19                “(B) *DETERMINATIONS.*—*The determina-*  
 20        *tion of whether an individual residing in a State*  
 21        *is a subsidy eligible individual and the amount*  
 22        *of such individual’s income shall be determined*  
 23        *under the State medicaid plan for the State*  
 24        *under section 1935(a). In the case of a State that*  
 25        *does not operate such a medicaid plan (either*

1        *under title XIX or under a statewide waiver*  
 2        *granted under section 1115), such determination*  
 3        *shall be made under arrangements made by the*  
 4        *Medicare Benefits Administrator.*

5                *“(C) INCOME DETERMINATIONS.—For pur-*  
 6        *poses of applying this section—*

7                *“(i) income shall be determined in the*  
 8                *manner described in section 1905(p)(1)(B);*  
 9                *and*

10               *“(ii) the term ‘Federal poverty line’*  
 11               *means the official poverty line (as defined*  
 12               *by the Office of Management and Budget,*  
 13               *and revised annually in accordance with*  
 14               *section 673(2) of the Omnibus Budget Rec-*  
 15               *onciliation Act of 1981) applicable to a*  
 16               *family of the size involved.*

17               *“(D) TREATMENT OF TERRITORIAL RESI-*  
 18        *DENTS.—In the case of an individual who is not*  
 19        *a resident of the 50 States or the District of Co-*  
 20        *lumbia, the individual is not eligible to be a sub-*  
 21        *sidy eligible individual but may be eligible for*  
 22        *financial assistance with prescription drug ex-*  
 23        *penses under section 1935(e).*

24        *“(b) PREMIUM SUBSIDY AMOUNT.—*

1           “(1) *IN GENERAL.*—*The premium subsidy*  
 2           *amount described in this subsection for an individual*  
 3           *residing in an area is the reference premium (as de-*  
 4           *fin ed in paragraph (2)) for qualified prescription*  
 5           *drug coverage offered by the prescription drug plan or*  
 6           *the Medicare+Choice plan in which the individual is*  
 7           *enrolled.*

8           “(2) *REFERENCE PREMIUM DEFINED.*—*For pur-*  
 9           *poses of this subsection, the term ‘reference premium’*  
 10           *means, with respect to qualified prescription drug*  
 11           *coverage offered under—*

12                   “(A) *a prescription drug plan that—*

13                           “(i) *provides standard coverage (or al-*  
 14                           *ternative prescription drug coverage the ac-*  
 15                           *tuarial value is equivalent to that of stand-*  
 16                           *ard coverage), the premium imposed for en-*  
 17                           *rollment under the plan under this part*  
 18                           *(determined without regard to any subsidy*  
 19                           *under this section or any late enrollment*  
 20                           *penalty under section 1860A(c)(2)(B)); or*

21                           “(ii) *provides alternative prescription*  
 22                           *drug coverage the actuarial value of which*  
 23                           *is greater than that of standard coverage,*  
 24                           *the premium described in clause (i) multi-*  
 25                           *plied by the ratio of (I) the actuarial value*

1                   of standard coverage, to (II) the actuarial  
2                   value of the alternative coverage; or

3                   “(B) a Medicare+Choice plan, the standard  
4                   premium       computed       under       section  
5                   1851(j)(4)(A)(iii), determined without regard to  
6                   any       reduction       effected       under       section  
7                   1851(j)(4)(B).

8           “(c) RULES IN APPLYING COST-SHARING SUB-  
9   SIDIES.—

10                   “(1) IN GENERAL.—In applying subsection  
11                   (a)(1)(B)—

12                   “(A) the maximum amount of subsidy that  
13                   may be provided with respect to an enrollee for  
14                   a year may not exceed 95 percent of the max-  
15                   imum cost-sharing described in such subsection  
16                   that may be incurred for standard coverage;

17                   “(B) the Medicare Benefits Administrator  
18                   shall determine what is ‘nominal’ taking into ac-  
19                   count the rules applied under section 1916(a)(3);  
20                   and

21                   “(C) nothing in this part shall be construed  
22                   as preventing a plan or provider from waiving  
23                   or reducing the amount of cost-sharing otherwise  
24                   applicable.

1           “(2) *LIMITATION ON CHARGES.*—*In the case of*  
2           *an individual receiving cost-sharing subsidies under*  
3           *subsection (a)(1)(B), the PDP sponsor may not*  
4           *charge more than a nominal amount in cases in*  
5           *which the cost-sharing subsidy is provided under such*  
6           *subsection.*

7           “(d) *ADMINISTRATION OF SUBSIDY PROGRAM.*—*The*  
8           *Medicare Benefits Administrator shall provide a process*  
9           *whereby, in the case of an individual who is determined*  
10          *to be a subsidy eligible individual and who is enrolled in*  
11          *prescription drug plan or is enrolled in a Medicare+Choice*  
12          *plan under which qualified prescription drug coverage is*  
13          *provided—*

14               “(1) *the Administrator provides for a notifica-*  
15               *tion of the PDP sponsor or Medicare+Choice organi-*  
16               *zation involved that the individual is eligible for a*  
17               *subsidy and the amount of the subsidy under sub-*  
18               *section (a);*

19               “(2) *the sponsor or organization involved reduces*  
20               *the premiums or cost-sharing otherwise imposed by*  
21               *the amount of the applicable subsidy and submits to*  
22               *the Administrator information on the amount of such*  
23               *reduction; and*

1           “(3) *the Administrator periodically and on a*  
 2           *timely basis reimburses the sponsor or organization*  
 3           *for the amount of such reductions.*

4           *The reimbursement under paragraph (3) with respect to*  
 5           *cost-sharing subsidies may be computed on a capitated*  
 6           *basis, taking into account the actuarial value of the sub-*  
 7           *sidies and with appropriate adjustments to reflect dif-*  
 8           *ferences in the risks actually involved.*

9           “(e) *RELATION TO MEDICAID PROGRAM.—*

10           “(1) *IN GENERAL.—For provisions providing for*  
 11           *eligibility determinations, and additional financing,*  
 12           *under the medicaid program, see section 1935.*

13           “(2) *MEDICAID PROVIDING WRAP AROUND BENE-*  
 14           *FITS.—The coverage provided under this part is pri-*  
 15           *mary payor to benefits for prescribed drugs provided*  
 16           *under the medicaid program under title XIX.*

17           **“SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENE-**  
 18           **FICIARIES THROUGH REINSURANCE FOR**  
 19           **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

20           “(a) *REINSURANCE SUBSIDY PAYMENT.—In order to*  
 21           *reduce premium levels applicable to qualified prescription*  
 22           *drug coverage for all medicare beneficiaries, to reduce ad-*  
 23           *verse selection among prescription drug plans and*  
 24           *Medicare+Choice plans that provide qualified prescription*  
 25           *drug coverage, and to promote the participation of PDP*

1 sponsors under this part, the Medicare Benefits Adminis-  
 2 trator shall provide in accordance with this section for pay-  
 3 ment to a qualifying entity (as defined in subsection (b))  
 4 of the reinsurance payment amount (as defined in sub-  
 5 section (c)) for excess costs incurred in providing qualified  
 6 prescription drug coverage—

7 “(1) for individuals enrolled with a prescription  
 8 drug plan under this part;

9 “(2) for individuals enrolled with a  
 10 Medicare+Choice plan that provides qualified pre-  
 11 scription drug coverage under part C; and

12 “(3) for medicare primary individuals (described  
 13 in subsection (f)(3)(D)) who are enrolled in a quali-  
 14 fied retiree prescription drug plan.

15 This section constitutes budget authority in advance of ap-  
 16 propriations Acts and represents the obligation of the Ad-  
 17 ministrator to provide for the payment of amounts provided  
 18 under this section.

19 “(b) *QUALIFYING ENTITY DEFINED.*—For purposes of  
 20 this section, the term ‘qualifying entity’ means any of the  
 21 following that has entered into an agreement with the Ad-  
 22 ministrator to provide the Administrator with such infor-  
 23 mation as may be required to carry out this section:

24 “(1) A PDP sponsor offering a prescription drug  
 25 plan under this part.

1           “(2) *A Medicare+Choice organization that pro-*  
 2           *vides qualified prescription drug coverage under a*  
 3           *Medicare+Choice plan under part C.*

4           “(3) *The sponsor of a qualified retiree prescrip-*  
 5           *tion drug plan (as defined in subsection (f)).*

6           “(c) *REINSURANCE PAYMENT AMOUNT.—*

7           “(1) *IN GENERAL.—Subject to subsection (d)(2)*  
 8           *and paragraph (4), the reinsurance payment amount*  
 9           *under this subsection for a qualifying covered indi-*  
 10           *vidual (as defined in subsection (g)(1)) for a coverage*  
 11           *year (as defined in subsection (g)(2)) is equal to the*  
 12           *sum of the following:*

13           “(A) *For the portion of the individual’s*  
 14           *gross covered prescription drug costs (as defined*  
 15           *in paragraph (3)) for the year that exceeds*  
 16           *\$1,250, but does not exceed \$1,350, an amount*  
 17           *equal to 30 percent of the allowable costs (as de-*  
 18           *finied in paragraph (2)) attributable to such*  
 19           *gross covered prescription drug costs.*

20           “(B) *For the portion of the individual’s*  
 21           *gross covered prescription drug costs for the year*  
 22           *that exceeds \$1,350, but does not exceed \$1,450,*  
 23           *an amount equal to 50 percent of the allowable*  
 24           *costs attributable to such gross covered prescrip-*  
 25           *tion drug costs.*

1           “(C) For the portion of the individual’s  
2           gross covered prescription drug costs for the year  
3           that exceeds \$1,450, but does not exceed \$1,550,  
4           an amount equal to 70 percent of the allowable  
5           costs attributable to such gross covered prescrip-  
6           tion drug costs.

7           “(D) For the portion of the individual’s  
8           gross covered prescription drug costs for the year  
9           that exceeds \$1,550, but does not exceed \$2,350,  
10          an amount equal to 90 percent of the allowable  
11          costs attributable to such gross covered prescrip-  
12          tion drug costs.

13          “(E) For the portion of the individual’s  
14          gross covered prescription drug costs for the year  
15          that exceeds \$7,050, an amount equal to 90 per-  
16          cent of the allowable costs attributable to such  
17          gross covered prescription drug costs.

18          “(2) ALLOWABLE COSTS.—For purposes of this  
19          section, the term ‘allowable costs’ means, with respect  
20          to gross covered prescription drug costs under a plan  
21          described in subsection (b) offered by a qualifying en-  
22          tity, the part of such costs that are actually paid  
23          under the plan, but in no case more than the part of  
24          such costs that would have been paid under the plan

1       *if the prescription drug coverage under the plan were*  
 2       *standard coverage.*

3               “(3) *GROSS COVERED PRESCRIPTION DRUG*  
 4       *COSTS.—For purposes of this section, the term ‘gross*  
 5       *covered prescription drug costs’ means, with respect to*  
 6       *an enrollee with a qualifying entity under a plan de-*  
 7       *scribed in subsection (b) during a coverage year, the*  
 8       *costs incurred under the plan for covered prescription*  
 9       *drugs dispensed during the year, including costs re-*  
 10       *lating to the deductible, whether paid by the enrollee*  
 11       *or under the plan, regardless of whether the coverage*  
 12       *under the plan exceeds standard coverage and regard-*  
 13       *less of when the payment for such drugs is made.*

14               “(4) *INDEXING DOLLAR AMOUNTS.—*

15               “(A) *AMOUNTS FOR 2003.—The dollar*  
 16       *amounts applied under paragraph (1) for 2003*  
 17       *shall be the dollar amounts specified in such*  
 18       *paragraph.*

19               “(B) *FOR 2004.—The dollar amounts ap-*  
 20       *plied under paragraph (1) for 2004 shall be the*  
 21       *dollar amounts specified in such paragraph in-*  
 22       *creased by the annual percentage increase de-*  
 23       *scribed in section 1860B(b)(5) for 2004.*

24               “(C) *FOR SUBSEQUENT YEARS.—The dollar*  
 25       *amounts applied under paragraph (1) for a year*

1       *after 2004 shall be the amounts (under this*  
 2       *paragraph) applied under paragraph (1) for the*  
 3       *preceding year increased by the annual percent-*  
 4       *age increase described in section 1860B(b)(5) for*  
 5       *the year involved.*

6               “(D) *ROUNDING.*—*Any amount, determined*  
 7       *under the preceding provisions of this paragraph*  
 8       *for a year, which is not a multiple of \$5 shall*  
 9       *be rounded to the nearest multiple of \$5.*

10       “(d) *ADJUSTMENT OF PAYMENTS.*—

11               “(1) *IN GENERAL.*—*The Medicare Benefits Ad-*  
 12       *ministrator shall estimate—*

13               “(A) *the total payments to be made (with-*  
 14       *out regard to this subsection) during a year*  
 15       *under this section; and*

16               “(B) *the total payments to be made by*  
 17       *qualifying entities for standard coverage under*  
 18       *plans described in subsection (b) during the year.*

19               “(2) *ADJUSTMENT OF PAYMENTS.*—*The Adminis-*  
 20       *trator shall proportionally adjust the payments made*  
 21       *under this section for a coverage year in such manner*  
 22       *so that the total of the payments made for the year*  
 23       *under this section is equal to 35 percent of the total*  
 24       *payments described in paragraph (1)(B) during the*  
 25       *year.*

1       “(e) *PAYMENT METHODS.*—

2               “(1) *IN GENERAL.*—*Payments under this section*  
 3       *shall be based on such a method as the Medicare Ben-*  
 4       *efits Administrator determines. The Administrator*  
 5       *may establish a payment method by which interim*  
 6       *payments of amounts under this section are made*  
 7       *during a year based on the Administrator’s best esti-*  
 8       *mate of amounts that will be payable after obtaining*  
 9       *all of the information.*

10              “(2) *SOURCE OF PAYMENTS.*—*Payments under*  
 11       *this section shall be made from the Medicare Prescrip-*  
 12       *tion Drug Account.*

13       “(f) *QUALIFIED RETIREE PRESCRIPTION DRUG PLAN*  
 14       *DEFINED.*—

15              “(1) *IN GENERAL.*—*For purposes of this section,*  
 16       *the term ‘qualified retiree prescription drug plan’*  
 17       *means employment-based retiree health coverage (as*  
 18       *defined in paragraph (3)(A)) if, with respect to an*  
 19       *individual enrolled (or eligible to be enrolled) under*  
 20       *this part who is covered under the plan, the following*  
 21       *requirements are met:*

22                      “(A) *ASSURANCE.*—*The sponsor of the plan*  
 23               *shall annually attest, and provide such assur-*  
 24               *ances as the Medicare Benefits Administrator*

1        *may require, that the coverage meets the require-*  
2        *ments for qualified prescription drug coverage.*

3                *“(B) AUDITS.—The sponsor (and the plan)*  
4        *shall maintain, and afford the Medicare Benefits*  
5        *Administrator access to, such records as the Ad-*  
6        *ministrator may require for purposes of audits*  
7        *and other oversight activities necessary to ensure*  
8        *the adequacy of prescription drug coverage, the*  
9        *accuracy of payments made, and such other mat-*  
10       *ters as may be appropriate.*

11               *“(C) PROVISION OF CERTIFICATION OF PRE-*  
12       *SCRIPTION DRUG COVERAGE.—The sponsor of the*  
13       *plan shall provide for issuance of certifications*  
14       *of the type described in section 1860A(c)(2)(D).*

15               *“(D) OTHER REQUIREMENTS.—The sponsor*  
16       *of the plan shall comply with such other require-*  
17       *ments as the Medicare Benefits Administrator*  
18       *finds necessary to administer the program under*  
19       *this section.*

20               *“(2) LIMITATION ON BENEFIT ELIGIBILITY.—No*  
21       *payment shall be provided under this section with re-*  
22       *spect to an individual who is enrolled under a quali-*  
23       *fied retiree prescription drug plan unless the indi-*  
24       *vidual is a medicare primary individual who—*

25               *“(A) is covered under the plan; and*

“(B) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

“(3) DEFINITIONS.—As used in this section:

“(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term ‘employment-based retiree health coverage’ means health insurance or other coverage of health care costs for medicare primary individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

“(B) EMPLOYER.—The term ‘employer’ has the meaning given such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of two or more employees).

“(C) SPONSOR.—The term ‘sponsor’ means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

“(D) MEDICARE PRIMARY INDIVIDUAL.—The term ‘medicare primary individual’ means,

1           *with respect to a plan, an individual who is cov-*  
2           *ered under the plan and with respect to whom*  
3           *the plan is not a primary plan (as defined in*  
4           *section 1862(b)(2)(A)).*

5           “(g) *GENERAL DEFINITIONS.—For purposes of this*  
6           *section:*

7           “(1) *QUALIFYING COVERED INDIVIDUAL.—The*  
8           *term ‘qualifying covered individual’ means an indi-*  
9           *vidual who—*

10           *“(A) is enrolled with a prescription drug*  
11           *plan under this part;*

12           *“(B) is enrolled with a Medicare+Choice*  
13           *plan that provides qualified prescription drug*  
14           *coverage under part C; or*

15           *“(C) is covered as a medicare primary indi-*  
16           *vidual under a qualified retiree prescription*  
17           *drug plan.*

18           “(2) *COVERAGE YEAR.—The term ‘coverage year’*  
19           *means a calendar year in which covered outpatient*  
20           *drugs are dispensed if a claim for payment is made*  
21           *under the plan for such drugs, regardless of when the*  
22           *claim is paid.*

1 **“SEC. 1860I. MEDICARE PRESCRIPTION DRUG ACCOUNT IN**  
 2 **FEDERAL SUPPLEMENTARY MEDICAL INSUR-**  
 3 **ANCE TRUST FUND.**

4 “(a) *IN GENERAL.*—*There is created within the Fed-*  
 5 *eral Supplementary Medical Insurance Trust Fund estab-*  
 6 *lished by section 1841 an account to be known as the ‘Medi-*  
 7 *care Prescription Drug Account’ (in this section referred*  
 8 *to as the ‘Account’). The Account shall consist of such gifts*  
 9 *and bequests as may be made as provided in section*  
 10 *201(i)(1), and such amounts as may be deposited in, or*  
 11 *appropriated to, such fund as provided in this part. Funds*  
 12 *provided under this part to the Account shall be kept sepa-*  
 13 *rate from all other funds within the Federal Supplementary*  
 14 *Medical Insurance Trust Fund.*

15 “(b) *PAYMENTS FROM ACCOUNT.*—

16 “(1) *IN GENERAL.*—*The Managing Trustee shall*  
 17 *pay from time to time from the Account such*  
 18 *amounts as the Medicare Benefits Administrator cer-*  
 19 *tifies are necessary to make—*

20 “(A) *payments under section 1860G (relat-*  
 21 *ing to low-income subsidy payments);*

22 “(B) *payments under section 1860H (relat-*  
 23 *ing to reinsurance subsidy payments); and*

24 “(C) *payments with respect to administra-*  
 25 *tive expenses under this part in accordance with*  
 26 *section 201(g).*

1           “(2) *TRANSFERS TO MEDICAID ACCOUNT FOR IN-*  
 2           *CREASED ADMINISTRATIVE COSTS.—The Managing*  
 3           *Trustee shall transfer from time to time from the Ac-*  
 4           *count to the Grants to States for Medicaid account*  
 5           *amounts the Secretary certifies are attributable to in-*  
 6           *creases in payment resulting from the application of*  
 7           *a higher Federal matching percentage under section*  
 8           *1935(b).*

9           “(3) *TREATMENT IN RELATION TO PART B PRE-*  
 10          *MIUM.—Amounts payable from the Account shall not*  
 11          *be taken into account in computing actuarial rates or*  
 12          *premium amounts under section 1839.*

13          “(c) *DEPOSITS INTO ACCOUNT.—*

14                 “(1) *MEDICAID TRANSFER.—There is hereby*  
 15                 *transferred to the Account, from amounts appro-*  
 16                 *priated for Grants to States for Medicaid, amounts*  
 17                 *equivalent to the aggregate amount of the reductions*  
 18                 *in payments under section 1903(a)(1) attributable to*  
 19                 *the application of section 1935(c).*

20                 “(2) *APPROPRIATIONS TO COVER GOVERNMENT*  
 21                 *CONTRIBUTIONS.—There are authorized to be appro-*  
 22                 *priated from time to time, out of any moneys in the*  
 23                 *Treasury not otherwise appropriated, to the Account,*  
 24                 *an amount equivalent to the amount of payments*  
 25                 *made from the Account under subsection (b), reduced*

1       *by the amount transferred to the Account under para-*  
 2       *graph (1).*

3       **“SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES**  
 4               **TO PROVISIONS IN PART C.**

5       “(a) *DEFINITIONS.*—*For purposes of this part:*

6               “(1) *COVERED OUTPATIENT DRUGS.*—*The term*  
 7       *‘covered outpatient drugs’ is defined in section*  
 8       *1860B(f).*

9               “(2) *INITIAL COVERAGE LIMIT.*—*The term ‘ini-*  
 10       *tial coverage limit’ means the such limit as estab-*  
 11       *lished under section 1860B(b)(3), or, in the case of*  
 12       *coverage that is not standard coverage, the com-*  
 13       *parable limit (if any) established under the coverage.*

14              “(3) *MEDICARE PRESCRIPTION DRUG AC-*  
 15       *COUNT.*—*The term ‘Medicare Prescription Drug Ac-*  
 16       *count’ means the Account in the Federal Supple-*  
 17       *mentary Medical Insurance Trust Fund created*  
 18       *under section 1860I(a).*

19              “(4) *PDP SPONSOR.*—*The term ‘PDP sponsor’*  
 20       *means an entity that is certified under this part as*  
 21       *meeting the requirements and standards of this part*  
 22       *for such a sponsor.*

23              “(5) *PRESCRIPTION DRUG PLAN.*—*The term ‘pre-*  
 24       *scription drug plan’ means health benefits coverage*  
 25       *that—*

1           “(A) is offered under a policy, contract, or  
 2           plan by a PDP sponsor pursuant to, and in ac-  
 3           cordance with, a contract between the Medicare  
 4           Benefits Administrator and the sponsor under  
 5           section 1860D(b);

6           “(B) provides qualified prescription drug  
 7           coverage; and

8           “(C) meets the applicable requirements of  
 9           the section 1860C for a prescription drug plan.

10          “(6) QUALIFIED PRESCRIPTION DRUG COV-  
 11          ERAGE.—The term ‘qualified prescription drug cov-  
 12          erage’ is defined in section 1860B(a).

13          “(7) STANDARD COVERAGE.—The term ‘standard  
 14          coverage’ is defined in section 1860B(b).

15          “(b) APPLICATION OF MEDICARE+CHOICE PROVI-  
 16          SIONS UNDER THIS PART.—For purposes of applying pro-  
 17          visions of part C under this part with respect to a prescrip-  
 18          tion drug plan and a PDP sponsor, unless otherwise pro-  
 19          vided in this part such provisions shall be applied as if—

20               “(1) any reference to a Medicare+Choice plan  
 21               included a reference to a prescription drug plan;

22               “(2) any reference to a provider-sponsored orga-  
 23               nization included a reference to a PDP sponsor;

1           “(3) any reference to a contract under section  
2           1857 included a reference to a contract under section  
3           1860D(b); and

4           “(4) any reference to part C included a reference  
5           to this part.”.

6           (b) CONFORMING AMENDMENTS TO FEDERAL SUPPLE-  
7           MENTARY MEDICAL INSURANCE TRUST FUND.—Section  
8           1841 of the Social Security Act (42 U.S.C. 1395t) is  
9           amended—

10           (1) in the last sentence of subsection (a)—

11                   (A) by striking “and” before “such  
12                   amounts”, and

13                   (B) by inserting before the period the fol-  
14                   lowing: “and such amounts as may be deposited  
15                   in, or appropriated to, the Medicare Prescription  
16                   Drug Account established by section 1860I”; and

17           (2) in subsection (g), by inserting after “by this  
18           part,” the following: “the payments provided for  
19           under part D (in which case the payments shall come  
20           from the Medicare Prescription Drug Account in the  
21           Trust Fund),”.

22           (c) ADDITIONAL CONFORMING CHANGES.—

23           (1) CONFORMING REFERENCES TO PREVIOUS  
24           PART D.—Any reference in law (in effect before the  
25           date of the enactment of this Act) to part D of title

1 *XVIII of the Social Security Act is deemed a reference*  
 2 *to part E of such title (as in effect after such date).*

3 (2) *SECRETARIAL SUBMISSION OF LEGISLATIVE*  
 4 *PROPOSAL.*—Not later than 6 months after the date of  
 5 the enactment of this Act, the Secretary of Health and  
 6 Human Services shall submit to the appropriate com-  
 7 mittees of Congress a legislative proposal providing  
 8 for such technical and conforming amendments in the  
 9 law as are required by the provisions of this subtitle.

10 **SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG**  
 11 **COVERAGE UNDER THE MEDICARE+CHOICE**  
 12 **PROGRAM.**

13 (a) *IN GENERAL.*—Section 1851 of the Social Security  
 14 Act (42 U.S.C. 1395w–21) is amended by adding at the  
 15 end the following new subsection:

16 “(j) *AVAILABILITY OF PRESCRIPTION DRUG BENE-*  
 17 *FITS.*—

18 “(1) *IN GENERAL.*—A Medicare+Choice organi-  
 19 zation may not offer prescription drug coverage (other  
 20 than that required under parts A and B) to an en-  
 21 rollee under a Medicare+Choice plan unless such  
 22 drug coverage is at least qualified prescription drug  
 23 coverage and unless the requirements of this sub-  
 24 section with respect to such coverage are met.

1           “(2) *COMPLIANCE WITH ADDITIONAL BENE-*  
2           *FICIARY PROTECTIONS.*—*With respect to the offering*  
3           *of qualified prescription drug coverage by a*  
4           *Medicare+Choice organization under a*  
5           *Medicare+Choice plan, the organization and plan*  
6           *shall meet the requirements of section 1860C, includ-*  
7           *ing requirements relating to information dissemina-*  
8           *tion and grievance and appeals, in the same manner*  
9           *as they apply to a PDP sponsor and a prescription*  
10           *drug plan under part D. The Medicare Benefits Ad-*  
11           *ministrator shall waive such requirements to the ex-*  
12           *tent the Administrator determines that such require-*  
13           *ments duplicate requirements otherwise applicable to*  
14           *the organization or plan under this part.*

15           “(3) *TREATMENT OF COVERAGE.*—*Except as pro-*  
16           *vided in this subsection, qualified prescription drug*  
17           *coverage offered under this subsection shall be treated*  
18           *under this part in the same manner as supplemental*  
19           *health care benefits described in section*  
20           *1852(a)(3)(A).*

21           “(4) *AVAILABILITY OF PREMIUM AND COST-SHAR-*  
22           *ING SUBSIDIES FOR LOW-INCOME ENROLLEES AND RE-*  
23           *INSURANCE SUBSIDY PAYMENTS FOR ORGANIZA-*  
24           *TIONS.*—*For provisions—*

1           “(A) providing premium and cost-sharing  
 2           subsidies to low-income individuals receiving  
 3           qualified prescription drug coverage through a  
 4           Medicare+Choice plan, see section 1860G; and

5           “(B) providing a Medicare+Choice organi-  
 6           zation with reinsurance subsidy payments for  
 7           providing qualified prescription drug coverage  
 8           under this part, see section 1860H.

9           “(5) SPECIFICATION OF SEPARATE AND STAND-  
 10          ARD PREMIUM.—

11           “(A) IN GENERAL.—For purposes of apply-  
 12           ing section 1854 and section 1860G(b)(2)(B)  
 13           with respect to qualified prescription drug cov-  
 14           erage offered under this subsection under a plan,  
 15           the Medicare+Choice organization shall compute  
 16           and publish the following:

17           “(i) SEPARATE PRESCRIPTION DRUG  
 18           PREMIUM.—A premium for prescription  
 19           drug benefits that constitute qualified pre-  
 20           scription drug coverage that is separate  
 21           from other coverage under the plan.

22           “(ii) PORTION OF COVERAGE ATTRIB-  
 23           UTABLE TO STANDARD BENEFITS.—The  
 24           ratio of the actuarial value of standard cov-  
 25           erage to the actuarial value of the qualified

1           *prescription drug coverage offered under the*  
 2           *plan.*

3           “(iii) *PORTION OF PREMIUM ATTRIB-*  
 4           *UTABLE TO STANDARD BENEFITS.—A stand-*  
 5           *ard premium equal to the product of the*  
 6           *premium described in clause (i) and the*  
 7           *ratio under clause (ii).*

8           *The premium under clause (i) shall be compute*  
 9           *without regard to any reduction in the premium*  
 10          *permitted under subparagraph (B).*

11          “(B) *REDUCTION OF PREMIUMS AL-*  
 12          *LOWED.—Nothing in this subsection shall be con-*  
 13          *strued as preventing a Medicare+Choice organi-*  
 14          *zation from reducing the amount of a premium*  
 15          *charged for prescription drug coverage because of*  
 16          *the application of section 1854(f)(1)(A) to other*  
 17          *coverage.*

18          “(C) *ACCEPTANCE OF REFERENCE PREMIUM*  
 19          *AS FULL PREMIUM IF NO STANDARD (OR EQUIVA-*  
 20          *LENT) COVERAGE IN AN AREA.—For requirement*  
 21          *to accept reference premium as full premium if*  
 22          *there is no standard (or equivalent) coverage in*  
 23          *the area of a Medicare+Choice plan, see section*  
 24          *1860F(d).*

1           “(6) *TRANSITION IN INITIAL ENROLLMENT PE-*  
 2           *RIOD.*—Notwithstanding any other provision of this  
 3           part, the annual, coordinated election period under  
 4           subsection (e)(3)(B) for 2003 shall be the 6-month pe-  
 5           riod beginning with November 2002.

6           “(7) *QUALIFIED PRESCRIPTION DRUG COVERAGE;*  
 7           *STANDARD COVERAGE.*—For purposes of this part, the  
 8           terms ‘qualified prescription drug coverage’ and  
 9           ‘standard coverage’ have the meanings given such  
 10          terms in section 1860B.”.

11          (b) *CONFORMING AMENDMENTS.*—Section 1851 of such  
 12          Act (42 U.S.C. 1395w–21) is amended—

13               (1) in subsection (a)(1)—

14                       (A) by inserting “(other than qualified pre-  
 15                       scription drug benefits)” after “benefits”;

16                       (B) by striking the period at the end of sub-  
 17                       paragraph (B) and inserting a comma; and

18                       (C) by adding after and below subpara-  
 19                       graph (B) the following:

20                       “and may elect qualified prescription drug coverage  
 21                       in accordance with section 1860A.”; and

22               (2) in subsection (g)(1), by inserting “and sec-  
 23               tion 1860A(c)(2)(B)” after “in this subsection”.

1       (c) *EFFECTIVE DATE.*—*The amendments made by this*  
 2 *section apply to coverage provided on or after January 1,*  
 3 *2003.*

4 **SEC. 103. MEDICAID AMENDMENTS.**

5       (a) *DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-*  
 6 *COME SUBSIDIES.*—

7           (1) *REQUIREMENT.*—*Section 1902 of the Social*  
 8 *Security Act (42 U.S.C. 1396a) is amended—*

9               (A) *in subsection (a)—*

10                   (i) *by striking “and” at the end of*  
 11 *paragraph (64);*

12                   (ii) *by striking the period at the end of*  
 13 *paragraph (65) and inserting “; and”; and*

14                   (iii) *by inserting after paragraph (65)*  
 15 *the following new paragraph:*

16                   “(66) *provide for making eligibility determina-*  
 17 *tions under section 1935(a).”.*

18           (2) *NEW SECTION.*—*Title XIX of such Act is fur-*  
 19 *ther amended—*

20               (A) *by redesignating section 1935 as section*  
 21 *1936; and*

22               (B) *by inserting after section 1934 the fol-*  
 23 *lowing new section:*

1           “SPECIAL PROVISIONS RELATING TO MEDICARE  
2                               *PRESCRIPTION DRUG BENEFIT*

3           “SEC. 1935. (a) *REQUIREMENT FOR MAKING ELIGI-*  
4 *BILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—*  
5 *As a condition of its State plan under this title under sec-*  
6 *tion 1902(a)(66) and receipt of any Federal financial as-*  
7 *sistance under section 1903(a), a State shall—*

8                       “(1) *make determinations of eligibility for pre-*  
9 *mium and cost-sharing subsidies under (and in ac-*  
10 *cordance with) section 1860G;*

11                      “(2) *inform the Administrator of the Medicare*  
12 *Benefits Administration of such determinations in*  
13 *cases in which such eligibility is established; and*

14                      “(3) *otherwise provide such Administrator with*  
15 *such information as may be required to carry out*  
16 *part D of title XVIII (including section 1860G).*

17           “(b) *PAYMENTS FOR ADDITIONAL ADMINISTRATIVE*  
18 *COSTS.—*

19                      “(1) *IN GENERAL.—The amounts expended by a*  
20 *State in carrying out subsection (a) are, subject to*  
21 *paragraph (2), expenditures reimbursable under the*  
22 *appropriate paragraph of section 1903(a); except*  
23 *that, notwithstanding any other provision of such sec-*  
24 *tion, the applicable Federal matching rates with re-*

1       *spect to such expenditures under such section shall be*  
2       *increased as follows:*

3               “(A) *For expenditures attributable to costs*  
4               *incurred during 2003, the otherwise applicable*  
5               *Federal matching rate shall be increased by 20*  
6               *percent of the percentage otherwise payable (but*  
7               *for this subsection) by the State.*

8               “(B) *For expenditures attributable to costs*  
9               *incurred during 2004, the otherwise applicable*  
10              *Federal matching rate shall be increased by 40*  
11              *percent of the percentage otherwise payable (but*  
12              *for this subsection) by the State.*

13              “(C) *For expenditures attributable to costs*  
14              *incurred during 2005, the otherwise applicable*  
15              *Federal matching rate shall be increased by 60*  
16              *percent of the percentage otherwise payable (but*  
17              *for this subsection) by the State.*

18              “(D) *For expenditures attributable to costs*  
19              *incurred during 2006, the otherwise applicable*  
20              *Federal matching rate shall be increased by 80*  
21              *percent of the percentage otherwise payable (but*  
22              *for this subsection) by the State.*

23              “(E) *For expenditures attributable to costs*  
24              *incurred after 2006, the otherwise applicable*

1           *Federal matching rate shall be increased to 100*  
 2           *percent.*

3           “(2) *COORDINATION.*—*The State shall provide*  
 4           *the Secretary with such information as may be nec-*  
 5           *essary to properly allocate administrative expendi-*  
 6           *tures described in paragraph (1) that may otherwise*  
 7           *be made for similar eligibility determinations.”.*

8           ***(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID***  
 9           ***RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-***  
 10           ***SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—***

11           ***(1) IN GENERAL.***—*Section 1903(a)(1) of the So-*  
 12           *cial Security Act (42 U.S.C. 1396b(a)(1)) is amended*  
 13           *by inserting before the semicolon the following: “, re-*  
 14           *duced by the amount computed under section*  
 15           *1935(c)(1) for the State and the quarter”.*

16           ***(2) AMOUNT DESCRIBED.***—*Section 1935 of such*  
 17           *Act, as inserted by subsection (a)(2), is amended by*  
 18           *adding at the end the following new subsection:*

19           ***“(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIP-***  
 20           ***TION DRUG COSTS FOR DUALY-ELIGIBLE BENE-***  
 21           ***FICIARIES.—***

22           ***“(1) IN GENERAL.***—*For purposes of section*  
 23           *1903(a)(1), for a State that is one of the 50 States*  
 24           *or the District of Columbia for a calendar quarter in*  
 25           *a year (beginning with 2003) the amount computed*

1        *under this subsection is equal to the product of the*  
 2        *following:*

3                “(A) *MEDICARE SUBSIDIES.*—*The total*  
 4                *amount of payments made in the quarter under*  
 5                *section 1860G (relating to premium and cost-*  
 6                *sharing prescription drug subsidies for low-in-*  
 7                *come medicare beneficiaries) that are attrib-*  
 8                *utable to individuals who are residents of the*  
 9                *State and are entitled to benefits with respect to*  
 10               *prescribed drugs under the State plan under this*  
 11               *title (including such a plan operating under a*  
 12               *waiver under section 1115).*

13               “(B) *STATE MATCHING RATE.*—*A propor-*  
 14               *tion computed by subtracting from 100 percent*  
 15               *the Federal medical assistance percentage (as de-*  
 16               *finied in section 1905(b)) applicable to the State*  
 17               *and the quarter.*

18               “(C) *PHASE-OUT PROPORTION.*—*The phase-*  
 19               *out proportion (as defined in paragraph (2)) for*  
 20               *the quarter.*

21               “(2) *PHASE-OUT PROPORTION.*—*For purposes of*  
 22               *paragraph (1)(C), the ‘phase-out proportion’ for a*  
 23               *calendar quarter in—*

24                        “(A) *2003 is 80 percent;*

25                        “(B) *2004 is 60 percent;*

1                   “(C) 2005 is 40 percent;

2                   “(D) 2006 is 20 percent; or

3                   “(E) a year after 2006 is 0 percent.”.

4           (c) *MEDICAID PROVIDING WRAP-AROUND BENE-*  
 5 *FITS.—Section 1935 of such Act, as so inserted and amend-*  
 6 *ed, is further amended by adding at the end the following*  
 7 *new subsection:*

8           “(d) *ADDITIONAL PROVISIONS.—*

9                   “(1) *MEDICAID AS SECONDARY PAYOR.—In the*  
 10 *case of an individual dually entitled to qualified pre-*  
 11 *scription drug coverage under a prescription drug*  
 12 *plan under part D of title XVIII (or under a*  
 13 *Medicare+Choice plan under part C of such title)*  
 14 *and medical assistance for prescribed drugs under*  
 15 *this title, medical assistance shall continue to be pro-*  
 16 *vided under this title for prescribed drugs to the ex-*  
 17 *tent payment is not made under the prescription drug*  
 18 *plan or the Medicare+Choice plan selected by the in-*  
 19 *dividual.*

20                   “(2) *CONDITION.—A State may require, as a*  
 21 *condition for the receipt of medical assistance under*  
 22 *this title with respect to prescription drug benefits for*  
 23 *an individual eligible to obtain qualified prescription*  
 24 *drug coverage described in paragraph (1), that the in-*

1 *dividual elect qualified prescription drug coverage*  
 2 *under section 1860A.”.*

3 *(d) TREATMENT OF TERRITORIES.—*

4 *(1) IN GENERAL.—Section 1935 of such Act, as*  
 5 *so inserted and amended, is further amended—*

6 *(A) in subsection (a) in the matter pre-*  
 7 *ceding paragraph (1), by inserting “subject to*  
 8 *subsection (e)” after “section 1903(a)”;*

9 *(B) in subsection (c)(1), by inserting “sub-*  
 10 *ject to subsection (e)” after “1903(a)(1)”;* and

11 *(C) by adding at the end the following new*  
 12 *subsection:*

13 *“(e) TREATMENT OF TERRITORIES.—*

14 *“(1) IN GENERAL.—In the case of a State, other*  
 15 *than the 50 States and the District of Columbia—*

16 *“(A) the previous provisions of this section*  
 17 *shall not apply to residents of such State; and*

18 *“(B) if the State establishes a plan de-*  
 19 *scribed in paragraph (2) (for providing medical*  
 20 *assistance with respect to the provision of pre-*  
 21 *scription drugs to medicare beneficiaries), the*  
 22 *amount otherwise determined under section*  
 23 *1108(f) (as increased under section 1108(g)) for*  
 24 *the State shall be increased by the amount speci-*  
 25 *fied in paragraph (3).*

1           “(2) *PLAN.*—*The plan described in this para-*  
 2           *graph is a plan that—*

3                   “(A) *provides medical assistance with re-*  
 4                   *spect to the provision of covered outpatient drugs*  
 5                   *(as defined in section 1860B(f)) to low-income*  
 6                   *medicare beneficiaries; and*

7                   “(B) *assures that additional amounts re-*  
 8                   *ceived by the State that are attributable to the*  
 9                   *operation of this subsection are used only for*  
 10                  *such assistance.*

11           “(3) *INCREASED AMOUNT.*—

12                   “(A) *IN GENERAL.*—*The amount specified*  
 13                   *in this paragraph for a State for a year is equal*  
 14                   *to the product of—*

15                           “(i) *the aggregate amount specified in*  
 16                           *subparagraph (B); and*

17                           “(ii) *the amount specified in section*  
 18                           *1108(g)(1) for that State, divided by the*  
 19                           *sum of the amounts specified in such section*  
 20                           *for all such States.*

21                   “(B) *AGGREGATE AMOUNT.*—*The aggregate*  
 22                   *amount specified in this subparagraph for—*

23                           “(i) *2003, is equal to \$20,000,000; or*

24                           “(ii) *a subsequent year, is equal to the*  
 25                           *aggregate amount specified in this subpara-*

1                   *graph for the previous year increased by*  
 2                   *annual percentage increase specified in sec-*  
 3                   *tion 1860(b)(5) for the year involved.*

4                   “(4) *REPORT.*—*The Secretary shall submit to*  
 5                   *Congress a report on the application of this subsection*  
 6                   *and may include in the report such recommendations*  
 7                   *as the Secretary deems appropriate.”.*

8                   (2) *CONFORMING AMENDMENT.*—*Section 1108(f)*  
 9                   *of such Act is amended by inserting “and section*  
 10                   *1935(e)(1)(B)” after “Subject to subsection (g)”.*

11   **SEC. 104. MEDIGAP TRANSITION PROVISIONS.**

12                   (a) *IN GENERAL.*—*Notwithstanding any other provi-*  
 13                   *sion of law, no new medicare supplemental policy that pro-*  
 14                   *vides coverage of expenses for prescription drugs may be*  
 15                   *issued under section 1882 of the Social Security Act on or*  
 16                   *after January 1, 2003, to an individual unless it replaces*  
 17                   *a medicare supplemental policy that was issued to that in-*  
 18                   *dividual and that provided some coverage of expenses for*  
 19                   *prescription drugs.*

20                   (b) *ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN*  
 21                   *PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE.*—

22                   (1) *IN GENERAL.*—*The issuer of a medicare sup-*  
 23                   *plemental policy—*

24                   (A) *may not deny or condition the issuance*  
 25                   *or effectiveness of a medicare supplemental pol-*

1            *icy that has a benefit package classified as “A”,*  
 2            *“B”, “C”, “D”, “E”, “F”, or “G” (under the*  
 3            *standards established under subsection (p)(2) of*  
 4            *section 1882 of the Social Security Act, 42*  
 5            *U.S.C. 1395ss) and that is offered and is avail-*  
 6            *able for issuance to new enrollees by such issuer;*

7            *(B) may not discriminate in the pricing of*  
 8            *such policy, because of health status, claims expe-*  
 9            *rience, receipt of health care, or medical condi-*  
 10           *tion; and*

11           *(C) may not impose an exclusion of benefits*  
 12           *based on a pre-existing condition under such pol-*  
 13           *icy,*

14           *in the case of an individual described in paragraph*  
 15           *(2) who seeks to enroll under the policy not later than*  
 16           *63 days after the date of the termination of enroll-*  
 17           *ment described in such paragraph and who submits*  
 18           *evidence of the date of termination or disenrollment*  
 19           *along with the application for such medicare supple-*  
 20           *mental policy.*

21           *(2) INDIVIDUAL COVERED.—An individual de-*  
 22           *scribed in this paragraph is an individual who—*

23           *(A) enrolls in a prescription drug plan*  
 24           *under part D of title XVIII of the Social Secu-*  
 25           *rity Act; and*

(B) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as “H”, “I”, or “J” under the standards referred to in paragraph (1)(A) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

(3) *ENFORCEMENT.*—The provisions of paragraph (1) shall be enforced as though they were included in section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)).

(4) *DEFINITIONS.*—For purposes of this subsection, the term “medicare supplemental policy” has the meaning given such term in section 1882(g) of the Social Security Act (42 U.S.C. 1395ss(g)).

**SEC. 105. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR SEVERELY CHRONICALLY ILL MEDICARE BENEFICIARIES.**

(a) *IN GENERAL.*—The Administrator of the Medicare Benefits Administration (in this section referred to as the “Administrator”) shall conduct a demonstration project under this section (in this section referred to as the “project”) to demonstrate the impact on costs and health outcomes of applying disease management to medicare

1 *beneficiaries with diagnosed, advanced-stage congestive*  
 2 *heart failure, diabetes, or coronary heart disease.*

3 *(b) VOLUNTARY PARTICIPATION.—*

4 *(1) ELIGIBILITY.—Medicare beneficiaries are eli-*  
 5 *gible to participate in the project only if—*

6 *(A) they meet specific medical criteria dem-*  
 7 *onstrating the appropriate diagnosis and the ad-*  
 8 *vanced nature of their disease;*

9 *(B) their physicians approve of participa-*  
 10 *tion in the project; and*

11 *(C) they are not enrolled in a*  
 12 *Medicare+Choice plan.*

13 *(2) BENEFITS.—A beneficiary who is enrolled in*  
 14 *the project shall be eligible—*

15 *(A) for disease management services related*  
 16 *to their chronic health condition; and*

17 *(B) if the beneficiary—*

18 *(i) is enrolled in a prescription drug*  
 19 *plan under part D of title XVIII of the So-*  
 20 *cial Security Act, for payment of any pre-*  
 21 *miums for such plan, any deductible or*  
 22 *cost-sharing, and any amounts not covered*  
 23 *under the plan because of the application of*  
 24 *an initial coverage limit; or*

1                   (ii) is not enrolled in such a plan, for  
 2                   payment for all costs for prescription drugs  
 3                   without regard to whether or not they relate  
 4                   to the chronic health condition;  
 5                   except that the project may provide for modest  
 6                   cost-sharing with respect to prescription drug  
 7                   coverage.

8                   (3) *TREATMENT AS QUALIFYING COVERAGE FOR*  
 9                   *PURPOSES OF CONTINUOUS COVERAGE.*—For purposes  
 10                  of applying section 1860A(c)(2)(C) of the Social Secu-  
 11                  rity Act, coverage under the project shall be treated as  
 12                  coverage under a prescription drug plan under part  
 13                  D of title XVIII of such Act.

14                  (c) *CONTRACTS WITH DISEASE MANAGEMENT ORGANI-*  
 15                  *ZATIONS.*—

16                  (1) *IN GENERAL.*—The Administrator shall carry  
 17                  out the project through contracts with up to 3 disease  
 18                  management organizations. The Administrator shall  
 19                  not enter into such a contract with an organization  
 20                  unless the organization demonstrates that it can  
 21                  produce improved health outcomes and reduce aggre-  
 22                  gate medicare expenditures consistent with paragraph  
 23                  (2).

24                  (2) *CONTRACT PROVISIONS.*—Under such  
 25                  contracts—

1           (A) such an organization shall be required  
2           to provide for prescription drug coverage de-  
3           scribed in subsection (b)(2)(B);

4           (B) such an organization shall be paid a fee  
5           negotiated and established by the Administrator  
6           in a manner so that (taking into account savings  
7           in expenditures under parts A and B of the  
8           medicare program) there will be a net reduction  
9           in expenditures under the medicare program as  
10          a result of the project; and

11          (C) such an organization shall guarantee,  
12          through an appropriate arrangement with a re-  
13          insurance company or otherwise, the net reduc-  
14          tion in expenditures described in subparagraph  
15          (B).

16          (3) *PAYMENTS.*—Payments to such organizations  
17          shall be made in appropriate proportion from the  
18          Trust Funds established under title XVIII of the So-  
19          cial Security Act.

20          (d) *DURATION.*—The project shall last for not longer  
21          than 3 years.

22          (e) *REPORT.*—The Administrator shall submit to Con-  
23          gress an interim report on the project not later than 2 years  
24          after the date it is first implemented and a final report  
25          on the project not later than 6 months after the date of its

1 completion. Such reports shall include information on the  
 2 impact of the project on costs and health outcomes and rec-  
 3 ommendations on the cost-effectiveness of extending or ex-  
 4 panding the project.

5 ***TITLE II—MODERNIZATION OF***  
 6 ***ADMINISTRATION OF MEDICARE***  
 7 ***Subtitle A—Medicare Benefits***  
 8 ***Administration***

9 ***SEC. 201. ESTABLISHMENT OF ADMINISTRATION.***

10 (a) *IN GENERAL.*—Title XVIII of the Social Security  
 11 Act (42 U.S.C. 1395 et seq.) is amended by inserting after  
 12 section 1806 the following new section:

13 “MEDICARE BENEFITS ADMINISTRATION

14 “SEC. 1807. (a) *ESTABLISHMENT.*—There is estab-  
 15 lished within the Department of Health and Human Serv-  
 16 ices an agency to be known as the Medicare Benefits Admin-  
 17 istration.

18 “(b) *ADMINISTRATOR AND DEPUTY ADMINIS-*  
 19 *TRATOR.*—

20 “(1) *ADMINISTRATOR.*—

21 “(A) *IN GENERAL.*—The Medicare Benefits  
 22 Administration shall be headed by an Adminis-  
 23 trator (in this section referred to as the ‘Admin-  
 24 istrator’) who shall be appointed by the Presi-  
 25 dent, by and with the advice and consent of the

1       *Senate. The Administrator shall be in direct line*  
2       *of authority to the Secretary.*

3               “(B) *COMPENSATION.*—*The Administrator*  
4       *shall be paid at the rate of basic pay payable for*  
5       *level III of the Executive Schedule under section*  
6       *5314 of title 5, United States Code.*

7               “(C) *TERM OF OFFICE.*—*The Administrator*  
8       *shall be appointed for a term of 5 years. In any*  
9       *case in which a successor does not take office at*  
10       *the end of an Administrator’s term of office, that*  
11       *Administrator may continue in office until the*  
12       *entry upon office of such a successor. An Admin-*  
13       *istrator appointed to a term of office after the*  
14       *commencement of such term may serve under*  
15       *such appointment only for the remainder of such*  
16       *term.*

17               “(D) *GENERAL AUTHORITY.*—*The Adminis-*  
18       *trator shall be responsible for the exercise of all*  
19       *powers and the discharge of all duties of the Ad-*  
20       *ministration, and shall have authority and con-*  
21       *trol over all personnel and activities thereof.*

22               “(E) *RULEMAKING AUTHORITY.*—*The Ad-*  
23       *ministrator may prescribe such rules and regula-*  
24       *tions as the Administrator determines necessary*  
25       *or appropriate to carry out the functions of the*

1       *Administration. The regulations prescribed by*  
2       *the Administrator shall be subject to the rule-*  
3       *making procedures established under section 553*  
4       *of title 5, United States Code.*

5               “(F) *AUTHORITY TO ESTABLISH ORGANIZA-*  
6       *TIONAL UNITS.—The Administrator may estab-*  
7       *lish, alter, consolidate, or discontinue such orga-*  
8       *nizational units or components within the Ad-*  
9       *ministration as the Administrator considers nec-*  
10       *essary or appropriate, except that this subpara-*  
11       *graph shall not apply with respect to any unit,*  
12       *component, or provision provided for by this sec-*  
13       *tion.*

14              “(G) *AUTHORITY TO DELEGATE.—The Ad-*  
15       *ministrator may assign duties, and delegate, or*  
16       *authorize successive redelegations of, authority to*  
17       *act and to render decisions, to such officers and*  
18       *employees of the Administration as the Adminis-*  
19       *trator may find necessary. Within the limita-*  
20       *tions of such delegations, redelegations, or as-*  
21       *signments, all official acts and decisions of such*  
22       *officers and employees shall have the same force*  
23       *and effect as though performed or rendered by*  
24       *the Administrator.*

25              “(2) *DEPUTY ADMINISTRATOR.—*

1           “(A) *IN GENERAL.*—*There shall be a Dep-*  
2           *uty Administrator of the Medicare Benefits Ad-*  
3           *ministration who shall be appointed by the*  
4           *President, by and with the advice and consent of*  
5           *the Senate.*

6           “(B) *COMPENSATION.*—*The Deputy Admin-*  
7           *istrator shall be paid at the rate of basic pay*  
8           *payable for level IV of the Executive Schedule*  
9           *under section 5315 of title 5, United States Code.*

10          “(C) *TERM OF OFFICE.*—*The Deputy Ad-*  
11          *ministrator shall be appointed for a term of 5*  
12          *years. In any case in which a successor does not*  
13          *take office at the end of a Deputy Administra-*  
14          *tor’s term of office, such Deputy Administrator*  
15          *may continue in office until the entry upon of-*  
16          *fice of such a successor. A Deputy Administrator*  
17          *appointed to a term of office after the commence-*  
18          *ment of such term may serve under such ap-*  
19          *pointment only for the remainder of such term.*

20          “(D) *DUTIES.*—*The Deputy Administrator*  
21          *shall perform such duties and exercise such pow-*  
22          *ers as the Administrator shall from time to time*  
23          *assign or delegate. The Deputy Administrator*  
24          *shall be Acting Administrator of the Administra-*  
25          *tion during the absence or disability of the Ad-*

1            *ministrator and, unless the President designates*  
 2            *another officer of the Government as Acting Ad-*  
 3            *ministrator, in the event of a vacancy in the of-*  
 4            *fice of the Administrator.*

5            “(3) *SECRETARIAL COORDINATION OF PROGRAM*  
 6            *ADMINISTRATION.—The Secretary shall ensure appro-*  
 7            *priate coordination between the Administrator and*  
 8            *the Administrator of the Health Care Financing Ad-*  
 9            *ministration in carrying out the programs under this*  
 10           *title.*

11           “(c) *DUTIES; ADMINISTRATIVE PROVISIONS.—*

12           “(1) *DUTIES.—*

13           “(A) *GENERAL DUTIES.—The Adminis-*  
 14           *trator shall carry out parts C and D,*  
 15           *including—*

16           “(i) *negotiating, entering into, and en-*  
 17           *forcing, contracts with plans for the offering*  
 18           *of Medicare+Choice plans under part C, in-*  
 19           *cluding the offering of qualified prescription*  
 20           *drug coverage under such plans; and*

21           “(ii) *negotiating, entering into, and*  
 22           *enforcing, contracts with PDP sponsors for*  
 23           *the offering of prescription drug plans*  
 24           *under part D.*

1           “(B) *OTHER DUTIES.*—*The Administrator*  
2           *shall carry out any duty provided for under part*  
3           *C or part D, including demonstration projects*  
4           *carried out in part or in whole under such parts,*  
5           *the programs of all-inclusive care for the elderly*  
6           *(PACE program) under section 1894, the social*  
7           *health maintenance organization (SHMO) dem-*  
8           *onstration projects (referred to in section 4104(c)*  
9           *of the Balanced Budget Act of 1997), and*  
10           *through a Medicare+Choice project that dem-*  
11           *onstrates the application of capitation payment*  
12           *rates for frail elderly medicare beneficiaries*  
13           *through the use of a interdisciplinary team and*  
14           *through the provision of primary care services to*  
15           *such beneficiaries by means of such a team at the*  
16           *nursing facility involved).*

17           “(C) *NONINTERFERENCE.*—*In carrying out*  
18           *its duties with respect to the provision of quali-*  
19           *fied prescription drug coverage to beneficiaries*  
20           *under this title, the Administrator may not—*

21                   “(i) *require a particular formulary or*  
22                   *institute a price structure for the reimburse-*  
23                   *ment of covered outpatient drugs;*

24                   “(ii) *interfere in any way with nego-*  
25                   *tiations between PDP sponsors and*

1           *Medicare+Choice organizations and drug*  
 2           *manufacturers, wholesalers, or other sup-*  
 3           *pliers of covered outpatient drugs; and*

4           “(iii) *otherwise interfere with the com-*  
 5           *petitive nature of providing such coverage*  
 6           *through such sponsors and organizations.*

7           “(D) *ANNUAL REPORTS.*—*Not later March*  
 8           *31 of each year, the Administrator shall submit*  
 9           *to Congress and the President a report on the*  
 10          *administration of parts C and D during the pre-*  
 11          *vious fiscal year.*

12          “(2) *STAFF.*—

13          “(A) *IN GENERAL.*—*The Administrator,*  
 14          *with the approval of the Secretary, may employ,*  
 15          *without regard to chapter 31 of title 5, United*  
 16          *States Code, such officers and employees as are*  
 17          *necessary to administer the activities to be car-*  
 18          *ried out through the Medicare Benefits Adminis-*  
 19          *tration.*

20          “(B) *FLEXIBILITY WITH RESPECT TO COM-*  
 21          *PENSATION.*—

22          “(i) *IN GENERAL.*—*The staff of the*  
 23          *Medicare Benefits Administration shall,*  
 24          *subject to clause (ii), be paid without regard*  
 25          *to the provisions of chapter 51 and chapter*

1           53 of such title (relating to classification  
2           and schedule pay rates).

3           “(ii) *MAXIMUM RATE.*—In no case  
4           may the rate of compensation determined  
5           under clause (i) exceed the rate of basic pay  
6           payable for level IV of the Executive Sched-  
7           ule under section 5315 of title 5, United  
8           States Code.

9           “(C) *LIMITATION ON FULL-TIME EQUIVA-*  
10          *LENT STAFFING FOR CURRENT HCFA FUNCTIONS*  
11          *BEING TRANSFERRED.*—The Administrator may  
12          not employ under this paragraph a number of  
13          full-time equivalent employees, to carry out func-  
14          tions that were previously conducted by the  
15          Health Care Financing Administration and that  
16          are conducted by the Administrator by reason of  
17          this section, that exceeds the number of such full-  
18          time equivalent employees authorized to be em-  
19          ployed by the Health Care Financing Adminis-  
20          tration to conduct such functions as of the date  
21          of the enactment of this Act.

22          “(3) *REDELEGATION OF CERTAIN FUNCTIONS OF*  
23          *THE HEALTH CARE FINANCING ADMINISTRATION.*—

24          “(A) *IN GENERAL.*—The Secretary, the Ad-  
25          ministrator, and the Administrator of the Health

1       *Care Financing Administration shall establish*  
2       *an appropriate transition of responsibility in*  
3       *order to redelegate the administration of part C*  
4       *from the Secretary and the Administrator of the*  
5       *Health Care Financing Administration to the*  
6       *Administrator as is appropriate to carry out the*  
7       *purposes of this section.*

8               “(B) *TRANSFER OF DATA AND INFORMA-*  
9       *TION.—The Secretary shall ensure that the Ad-*  
10       *ministrator of the Health Care Financing Ad-*  
11       *ministration transfers to the Administrator of*  
12       *the Medicare Benefits Administration such infor-*  
13       *mation and data in the possession of the Admin-*  
14       *istrator of the Health Care Financing Adminis-*  
15       *tration as the Administrator of the Medicare*  
16       *Benefits Administration requires to carry out the*  
17       *duties described in paragraph (1).*

18               “(C) *CONSTRUCTION.—Insofar as a respon-*  
19       *sibility of the Secretary or the Administrator of*  
20       *the Health Care Financing Administration is re-*  
21       *delegated to the Administrator under this sec-*  
22       *tion, any reference to the Secretary or the Ad-*  
23       *ministrator of the Health Care Financing Ad-*  
24       *ministration in this title or title XI with respect*

1           *to such responsibility is deemed to be a reference*  
 2           *to the Administrator.*

3           “(d) *OFFICE OF BENEFICIARY ASSISTANCE.*—

4                 “(1) *ESTABLISHMENT.*—*The Secretary shall es-*  
 5                 *tablish within the Medicare Benefits Administration*  
 6                 *an Office of Beneficiary Assistance to carry out func-*  
 7                 *tions relating to medicare beneficiaries under this*  
 8                 *title, including making determinations of eligibility of*  
 9                 *individuals for benefits under this title, providing for*  
 10                 *enrollment of medicare beneficiaries under this title,*  
 11                 *and the functions described in paragraph (2). The Of-*  
 12                 *fice shall be separate operating division within the*  
 13                 *Administration.*

14                 “(2) *DISSEMINATION OF INFORMATION ON BENE-*  
 15                 *FITS AND APPEALS RIGHTS.*—

16                 “(A) *DISSEMINATION OF BENEFITS INFOR-*  
 17                 *MATION.*—*The Office of Beneficiary Assistance*  
 18                 *shall disseminate to medicare beneficiaries, by*  
 19                 *mail, by posting on the Internet site of the Medi-*  
 20                 *care Benefits Administration and through the*  
 21                 *toll-free telephone number provided for under sec-*  
 22                 *tion 1804(b), information with respect to the fol-*  
 23                 *lowing:*

24                         “(i) *Benefits, and limitations on pay-*  
 25                         *ment (including cost-sharing, stop-loss pro-*

visions, and formulary restrictions) under parts C and D.

“(ii) *Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.*

*Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.*

“(B) *DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare+Choice program under part C, and the Voluntary Prescription Drug Benefit Program under part D.*

“(3) *MEDICARE OMBUDSMAN.—*

“(A) *IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare*

1           Ombudsman, appointed by the Secretary from  
2           among individuals with expertise and experience  
3           in the fields of health care and advocacy, to  
4           carry out the duties described in subparagraph  
5           (B).

6           “(B) DUTIES.—The Medicare Ombudsman  
7           shall—

8                   “(i) receive complaints, grievances, and  
9                   requests for information submitted by a  
10                  medicare beneficiary, with respect to any  
11                  aspect of the medicare program;

12                  “(ii) provide assistance with respect to  
13                  complaints, grievances, and requests re-  
14                  ferred to in clause (i), including—

15                           “(I) assistance in collecting rel-  
16                           evant information for such bene-  
17                           ficiaries, to seek an appeal of a deci-  
18                           sion or determination made by a fiscal  
19                           intermediary,                           carrier,  
20                           Medicare+Choice organization, a PDP  
21                           sponsor under part D, or the Sec-  
22                           retary; and

23                           “(II) assistance to such bene-  
24                           ficiaries with any problems arising  
25                           from disenrollment from a

1                   *Medicare+Choice plan under part C*  
 2                   *or a prescription drug plan under part*  
 3                   *D; and*

4                   “(iii) submit annual reports to Con-  
 5                   gress, the Secretary, and the Medicare Pol-  
 6                   icy Advisory Board describing the activities  
 7                   of the Office, and including such rec-  
 8                   ommendations for improvement in the ad-  
 9                   ministration of this title as the Ombudsman  
 10                  determines appropriate.

11                  “(C) COORDINATION WITH STATE OMBUDS-  
 12                  MAN PROGRAMS AND CONSUMER ORGANIZA-  
 13                  TIONS.—*The Medicare Ombudsman shall, to the*  
 14                  *extent appropriate, coordinate with State med-*  
 15                  *ical Ombudsman programs, and with State- and*  
 16                  *community-based consumer organizations, to—*

17                         “(i) provide information about the  
 18                         *medicare program; and*

19                         “(ii) conduct outreach to educate medi-  
 20                         *care beneficiaries with respect to manners*  
 21                         *in which problems under the medicare pro-*  
 22                         *gram may be resolved or avoided.*

23                  “(e) *MEDICARE POLICY ADVISORY BOARD.—*

24                         “(1) *ESTABLISHMENT.—There is established*  
 25                         *within the Medicare Benefits Administration the*

1     *Medicare Policy Advisory Board (in this section re-*  
2     *ferred to the ‘Board’). The Board shall advise, consult*  
3     *with, and make recommendations to the Adminis-*  
4     *trator of the Medicare Benefits Administration with*  
5     *respect to the administration of parts C and D, in-*  
6     *cluding the review of payment policies under such*  
7     *parts.*

8             “(2) *REPORTS.*—

9             “(A) *IN GENERAL.*—With respect to matters  
10            *of the administration of parts C and D, the*  
11            *Board shall submit to Congress and to the Ad-*  
12            *ministrator of the Medicare Benefits Administra-*  
13            *tion such reports as the Board determines appro-*  
14            *priate. Each such report may contain such rec-*  
15            *ommendations as the Board determines appro-*  
16            *priate for legislative or administrative changes*  
17            *to improve the administration of such parts, in-*  
18            *cluding the topics described in subparagraph*  
19            *(B). Each such report shall be published in the*  
20            *Federal Register.*

21            “(B) *TOPICS DESCRIBED.*—Reports required  
22            *under subparagraph (A) may include the fol-*  
23            *lowing topics:*

24                 “(i) *FOSTERING COMPETITION.*—*Rec-*  
25                 *ommendations or proposals to increase com-*

petition under parts C and D for services furnished to medicare beneficiaries.

“(ii) *EDUCATION AND ENROLLMENT.*—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

“(iii) *IMPLEMENTATION OF RISK-ADJUSTMENT.*—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare+Choice organizations offering Medicare+Choice plans that accounts for variations in per capita costs based on health status and other demographic factors.

“(iv) *DISEASE MANAGEMENT PROGRAMS.*—Recommendations on the incorporation of disease management programs under parts C and D.

“(v) *RURAL ACCESS.*—Recommendations to improve competition and access to plans under parts C and D in rural areas.

1           “(C) *MAINTAINING INDEPENDENCE OF*  
2           *BOARD.—The Board shall directly submit to*  
3           *Congress reports required under subparagraph*  
4           *(A). No officer or agency of the United States*  
5           *may require the Board to submit to any officer*  
6           *or agency of the United States for approval,*  
7           *comments, or review, prior to the submission to*  
8           *Congress of such reports.*

9           “(3) *DUTY OF ADMINISTRATOR OF MEDICARE*  
10          *BENEFITS ADMINISTRATION.—With respect to any re-*  
11          *port submitted by the Board under paragraph (2)(A),*  
12          *not later than 90 days after the report is submitted,*  
13          *the Administrator of the Medicare Benefits Adminis-*  
14          *tration shall submit to Congress and the President an*  
15          *analysis of recommendations made by the Board in*  
16          *such report. Each such analysis shall be published in*  
17          *the Federal Register.*

18          “(4) *MEMBERSHIP.—*

19                 “(A) *APPOINTMENT.—Subject to the suc-*  
20                 *ceeding provisions of this paragraph, the Board*  
21                 *shall consist of 7 members to be appointed as fol-*  
22                 *lows:*

23                         “(i) *3 members shall be appointed by*  
24                         *the President.*

1           “(ii) 2 members shall be appointed by  
2           the Speaker of the House of Representatives,  
3           with the advice of the chairman and the  
4           ranking minority member of the Commit-  
5           tees on Ways and Means and on Commerce  
6           of the House of Representatives.

7           “(iii) 2 members shall be appointed by  
8           the President pro tempore of the Senate  
9           with the advice of the chairman and the  
10          ranking minority member of the Senate  
11          Committee on Finance.

12          “(B) QUALIFICATIONS.—The members shall  
13          be chosen on the basis of their integrity, impar-  
14          tiality, and good judgment, and shall be individ-  
15          uals who are, by reason of their education and  
16          experience in health care benefits management,  
17          exceptionally qualified to perform the duties of  
18          members of the Board.

19          “(C) PROHIBITION ON INCLUSION OF FED-  
20          ERAL EMPLOYEES.—No officer or employee of the  
21          United States may serve as a member of the  
22          Board.

23          “(5) COMPENSATION.—Members of the Board  
24          shall receive, for each day (including travel time) they  
25          are engaged in the performance of the functions of the

1       *board, compensation at rates not to exceed the daily*  
 2       *equivalent to the annual rate in effect for level IV of*  
 3       *the Executive Schedule under section 5315 of title 5,*  
 4       *United States Code.*

5               “(6) *TERMS OF OFFICE.*—

6               “(A) *IN GENERAL.*—*The term of office of*  
 7       *members of the Board shall be 3 years.*

8               “(B) *TERMS OF INITIAL APPOINTEES.*—*As*  
 9       *designated by the President at the time of ap-*  
 10       *pointment, of the members first appointed—*

11               “(i) *1 shall be appointed for a term of*  
 12       *1 year;*

13               “(ii) *3 shall be appointed for terms of*  
 14       *2 years; and*

15               “(iii) *3 shall be appointed for terms of*  
 16       *3 years.*

17               “(C) *REAPPOINTMENTS.*—*Any person ap-*  
 18       *pointed as a member of the Board may not serve*  
 19       *for more than 8 years.*

20               “(D) *VACANCY.*—*Any member appointed to*  
 21       *fill a vacancy occurring before the expiration of*  
 22       *the term for which the member’s predecessor was*  
 23       *appointed shall be appointed only for the re-*  
 24       *mainder of that term. A member may serve after*  
 25       *the expiration of that member’s term until a suc-*

1           cessor has taken office. A vacancy in the Board  
2           shall be filled in the manner in which the origi-  
3           nal appointment was made.

4           “(7) CHAIR.—The Chair of the Board shall be  
5           elected by the members. The term of office of the Chair  
6           shall be 3 years.

7           “(8) MEETINGS.—The Board shall meet at the  
8           call of the Chair, but in no event less than 3 times  
9           during each fiscal year.

10          “(9) DIRECTOR AND STAFF.—

11               “(A) APPOINTMENT OF DIRECTOR.—The  
12           Board shall have a Director who shall be ap-  
13           pointed by the Chair.

14               “(B) IN GENERAL.—With the approval of  
15           the Board, the Director may appoint, without re-  
16           gard to chapter 31 of title 5, United States Code,  
17           such additional personnel as the Director con-  
18           siders appropriate.

19               “(C) FLEXIBILITY WITH RESPECT TO COM-  
20           PENSATION.—

21               “(i) IN GENERAL.—The Director and  
22           staff of the Board shall, subject to clause  
23           (ii), be paid without regard to the provi-  
24           sions of chapter 51 and chapter 53 of such

1                   *title (relating to classification and schedule*  
 2                   *pay rates).*

3                   “(ii) *MAXIMUM RATE.*—*In no case*  
 4                   *may the rate of compensation determined*  
 5                   *under clause (i) exceed the rate of basic pay*  
 6                   *payable for level IV of the Executive Sched-*  
 7                   *ule under section 5315 of title 5, United*  
 8                   *States Code.*

9                   “(D) *ASSISTANCE FROM THE ADMINIS-*  
 10                  *TRATOR OF THE MEDICARE BENEFITS ADMINIS-*  
 11                  *TRATION.*—*The Administrator of the Medicare*  
 12                  *Benefits Administration shall make available to*  
 13                  *the Board such information and other assistance*  
 14                  *as it may require to carry out its functions.*

15                  “(10) *CONTRACT AUTHORITY.*—*The Board may*  
 16                  *contract with and compensate government and pri-*  
 17                  *ivate agencies or persons to carry out its duties under*  
 18                  *this subsection, without regard to section 3709 of the*  
 19                  *Revised Statutes (41 U.S.C. 5).*

20                  “(f) *FUNDING.*—*There is authorized to be appro-*  
 21                  *priated, in appropriate part from the Federal Hospital In-*  
 22                  *surance Trust Fund and from the Federal Supplementary*  
 23                  *Medical Insurance Trust Fund (including the Medicare*  
 24                  *Prescription Drug Account), such sums as are necessary to*  
 25                  *carry out this section.”.*

1       (b) *EFFECTIVE DATE.*—

2               (1) *IN GENERAL.*—*The amendment made by sub-*  
 3       *section (a) shall take effect on the date of the enact-*  
 4       *ment of this Act.*

5               (2) *TIMING OF INITIAL APPOINTMENTS.*—*The Ad-*  
 6       *ministrator and Deputy Administrator of the Medi-*  
 7       *care Benefits Administration may not be appointed*  
 8       *before March 1, 2001.*

9               (3) *DUTIES WITH RESPECT TO ELIGIBILITY DE-*  
 10       *TERMINATIONS AND ENROLLMENT.*—*The Adminis-*  
 11       *trator of the Medicare Benefits Administration shall*  
 12       *carry out enrollment under title XVIII of the Social*  
 13       *Security Act, make eligibility determinations under*  
 14       *such title, and carry out part C of such title for years*  
 15       *beginning or after January 1, 2003.*

16   **SEC. 202. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.**

17       (a) *ADMINISTRATOR AS MEMBER OF THE BOARD OF*  
 18       *TRUSTEES OF THE MEDICARE TRUST FUNDS.*—*Section*  
 19       *1817(b) and section 1841(b) of the Social Security Act (42*  
 20       *U.S.C. 1395i(b), 1395t(b)) are each amended by striking*  
 21       *“and the Secretary of Health and Human Services, all ex*  
 22       *officio,” and inserting “the Secretary of Health and*  
 23       *Human Services, and the Administrator of the Medicare*  
 24       *Benefits Administration, all ex officio,”.*

1       (b) *INCREASE IN GRADE TO EXECUTIVE LEVEL III*  
 2       *FOR THE ADMINISTRATOR OF THE HEALTH CARE FINANC-*  
 3       *ING ADMINISTRATION.*—

4               (1) *IN GENERAL.*—Section 5314 of title 5,  
 5       *United States Code*, by adding at the end the fol-  
 6       *lowing:*

7               “*Administrator of the Health Care Financing*  
 8       *Administration.*”.

9               (2) *CONFORMING AMENDMENT.*—Section 5315 of  
 10       *such title is amended by striking “Administrator of*  
 11       *the Health Care Financing Administration.*”.

12              (3) *EFFECTIVE DATE.*—The amendments made  
 13       *by this subsection take effect on March 1, 2001.*

14       ***Subtitle B—Oversight of Financial***  
 15       ***Sustainability of the Medicare***  
 16       ***Program***

17       ***SEC. 211. ADDITIONAL REQUIREMENTS FOR ANNUAL FI-***  
 18                       ***NANCIAL REPORT AND OVERSIGHT ON MEDI-***  
 19                       ***CARE PROGRAM.***

20              (a) *IN GENERAL.*—Section 1817 of the Social Security  
 21       *Act (42 U.S.C. 1395i) is amended by adding at the end*  
 22       *the following new subsection:*

23              “(l) *COMBINED REPORT ON OPERATION AND STATUS*  
 24       *OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY*  
 25       *MEDICAL INSURANCE TRUST FUND.*—

1           “(1) *IN GENERAL.*—*In addition to the duty of*  
 2           *the Board of Trustees to report to Congress under sub-*  
 3           *section (b), on the date the Board submits the report*  
 4           *required under subsection (b)(2), the Board shall sub-*  
 5           *mit to Congress a report on the operation and status*  
 6           *of the Trust Fund and the Federal Supplementary*  
 7           *Medical Insurance Trust Fund established under sec-*  
 8           *tion 1841 (in this subsection referred to as the ‘Trust*  
 9           *Funds’). Such report shall included the following in-*  
 10          *formation:*

11                 “(A) *OVERALL SPENDING FROM THE GEN-*  
 12                 *ERAL FUND OF THE TREASURY.*—*A statement of*  
 13                 *total amounts obligated during the preceding fis-*  
 14                 *cal year from the General Revenues of the Treas-*  
 15                 *ury to the Trust Funds for payment for benefits*  
 16                 *covered under this title, stated in terms of the*  
 17                 *total amount and in terms of the percentage such*  
 18                 *amount bears to all other amounts obligated*  
 19                 *from such General Revenues during such fiscal*  
 20                 *year.*

21                 “(B) *HISTORICAL OVERVIEW OF SPEND-*  
 22                 *ING.*—*From the date of the inception of the pro-*  
 23                 *gram of insurance under this title through the*  
 24                 *fiscal year involved, a statement of the total*  
 25                 *amounts referred to in subparagraph (A).*

1           “(C) 10-YEAR AND 50-YEAR PROJECTIONS.—  
2           *An estimate of total amounts referred to in sub-*  
3           *paragraph (A) required to be obligated for pay-*  
4           *ment for benefits covered under this title for each*  
5           *of the 10 fiscal years succeeding the fiscal year*  
6           *involved and for the 50-year period beginning*  
7           *with the succeeding fiscal year.*

8           “(D) RELATION TO GDP GROWTH.—*A com-*  
9           *parison of the rate of growth of the total*  
10          *amounts referred to in subparagraph (A) to the*  
11          *rate of growth in the gross domestic product for*  
12          *the same period.*

13          “(2) PUBLICATION.—*Each report submitted*  
14          *under paragraph (1) shall be published by the Com-*  
15          *mittee on Ways and Means as a public document and*  
16          *shall be made available by such Committee on the*  
17          *Internet.”.*

18          “(b) EFFECTIVE DATE.—*The amendment made by sub-*  
19          *section (a) shall apply with respect to fiscal years beginning*  
20          *on or after the date of the enactment of this Act.*

21          “(c) CONGRESSIONAL HEARINGS.—*It is the sense of*  
22          *Congress that the committees of jurisdiction shall hold hear-*  
23          *ings on the reports submitted under section 1817(l) of the*  
24          *Social Security Act.*

1     ***Subtitle C—Changes in Medicare***  
 2     ***Coverage and Appeals Process***

3     ***SEC. 221. REVISIONS TO MEDICARE APPEALS PROCESS.***

4         *(a) CONDUCT OF RECONSIDERATIONS OF DETERMINA-*  
 5     *TIONS BY INDEPENDENT CONTRACTORS.—Section 1869 of*  
 6     *the Social Security Act (42 U.S.C. 1395ff) is amended to*  
 7     *read as follows:*

8                     “DETERMINATIONS; APPEALS

9         “SEC. 1869. (a) *INITIAL DETERMINATIONS.—The Sec-*  
 10     *retary shall promulgate regulations and make initial deter-*  
 11     *minations with respect to benefits under part A or part B*  
 12     *in accordance with those regulations for the following:*

13                 “(1) *The initial determination of whether an in-*  
 14     *dividual is entitled to benefits under such parts.*

15                 “(2) *The initial determination of the amount of*  
 16     *benefits available to the individual under such parts.*

17                 “(3) *Any other initial determination with re-*  
 18     *spect to a claim for benefits under such parts, includ-*  
 19     *ing an initial determination by the Secretary that*  
 20     *payment may not be made, or may no longer be*  
 21     *made, for an item or service under such parts, an ini-*  
 22     *tial determination made by a utilization and quality*  
 23     *control peer review organization under section*  
 24     *1154(a)(2), and an initial determination made by an*

1        *entity pursuant to a contract with the Secretary to*  
2        *administer provisions of this title or title XI.*

3        “(b) *APPEAL RIGHTS.*—

4                “(1) *IN GENERAL.*—

5                        “(A) *RECONSIDERATION OF INITIAL DETER-*  
6                        *MINATION.*—*Subject to subparagraph (D), any*  
7                        *individual dissatisfied with any initial deter-*  
8                        *mination under subsection (a) shall be entitled to*  
9                        *reconsideration of the determination, and, subject*  
10                       *to subparagraphs (D) and (E), a hearing thereon*  
11                       *by the Secretary to the same extent as is pro-*  
12                       *vided in section 205(b) and to judicial review of*  
13                       *the Secretary’s final decision after such hearing*  
14                       *as is provided in section 205(g).*

15                      “(B) *REPRESENTATION BY PROVIDER OR*  
16                      *SUPPLIER.*—

17                                “(i) *IN GENERAL.*—*Sections 206(a),*  
18                                *1102, and 1871 shall not be construed as*  
19                                *authorizing the Secretary to prohibit an in-*  
20                                *dividual from being represented under this*  
21                                *section by a person that furnishes or sup-*  
22                                *plies the individual, directly or indirectly,*  
23                                *with services or items, solely on the basis*  
24                                *that the person furnishes or supplies the in-*  
25                                *dividual with such a service or item.*

1           “(ii) *MANDATORY WAIVER OF RIGHT*  
2           *TO PAYMENT FROM BENEFICIARY.*—Any  
3           person that furnishes services or items to an  
4           individual may not represent an individual  
5           under this section with respect to the issue  
6           described in section 1879(a)(2) unless the  
7           person has waived any rights for payment  
8           from the beneficiary with respect to the  
9           services or items involved in the appeal.

10          “(iii) *PROHIBITION ON PAYMENT FOR*  
11          *REPRESENTATION.*—If a person furnishes  
12          services or items to an individual and rep-  
13          resents the individual under this section, the  
14          person may not impose any financial liabil-  
15          ity on such individual in connection with  
16          such representation.

17          “(iv) *REQUIREMENTS FOR REPRESENT-*  
18          *ATIVES OF A BENEFICIARY.*—The provisions  
19          of section 205(j) and section 206 (regarding  
20          representation of claimants) shall apply to  
21          representation of an individual with respect  
22          to appeals under this section in the same  
23          manner as they apply to representation of  
24          an individual under those sections.

1           “(C) *SUCCESSION OF RIGHTS IN CASES OF*  
2           *ASSIGNMENT.*—*The right of an individual to an*  
3           *appeal under this section with respect to an item*  
4           *or service may be assigned to the provider of*  
5           *services or supplier of the item or service upon*  
6           *the written consent of such individual using a*  
7           *standard form established by the Secretary for*  
8           *such an assignment.*

9           “(D) *TIME LIMITS FOR APPEALS.*—

10           “(i) *RECONSIDERATIONS.*—*Reconsider-*  
11           *ation under subparagraph (A) shall be*  
12           *available only if the individual described*  
13           *subparagraph (A) files notice with the Sec-*  
14           *retary to request reconsideration by not*  
15           *later than 180 days after the individual re-*  
16           *ceives notice of the initial determination*  
17           *under subsection (a) or within such addi-*  
18           *tional time as the Secretary may allow.*

19           “(ii) *HEARINGS CONDUCTED BY THE*  
20           *SECRETARY.*—*The Secretary shall establish*  
21           *in regulations time limits for the filing of*  
22           *a request for a hearing by the Secretary in*  
23           *accordance with provisions in sections 205*  
24           *and 206.*

25           “(E) *AMOUNTS IN CONTROVERSY.*—

1           “(i) *IN GENERAL.*—A hearing (by the  
 2           *Secretary*) shall not be available to an indi-  
 3           *vidual* under this section if the amount in  
 4           *controversy* is less than \$100, and judicial  
 5           *review* shall not be available to the indi-  
 6           *vidual* if the amount in controversy is less  
 7           than \$1,000.

8           “(ii) *AGGREGATION OF CLAIMS.*—In  
 9           *determining* the amount in controversy, the  
 10          *Secretary*, under regulations, shall allow 2  
 11          or more appeals to be aggregated if the ap-  
 12          peals involve—

13               “(I) *the delivery of similar or re-*  
 14               *lated services to the same individual by*  
 15               *one or more providers of services or*  
 16               *suppliers, or*

17               “(II) *common issues of law and*  
 18               *fact arising from services furnished to*  
 19               *2 or more individuals by one or more*  
 20               *providers of services or suppliers.*

21          “(F) *EXPEDITED PROCEEDINGS.*—

22               “(i) *EXPEDITED DETERMINATION.*—In  
 23               the case of an individual who—

24                       “(I) *has received notice by a pro-*  
 25                       *vider of services that the provider of*

1           *services plans to terminate services*  
2           *provided to an individual and a physi-*  
3           *cian certifies that failure to continue*  
4           *the provision of such services is likely*  
5           *to place the individual's health at sig-*  
6           *nificant risk, or*

7                     *“(II) has received notice by a pro-*  
8           *vider of services that the provider of*  
9           *services plans to discharge the indi-*  
10          *vidual from the provider of services,*  
11          *the individual may request, in writing or*  
12          *orally, an expedited determination or an ex-*  
13          *pedited reconsideration of an initial deter-*  
14          *mination made under subsection (a), as the*  
15          *case may be, and the Secretary shall pro-*  
16          *vide such expedited determination or expe-*  
17          *dited reconsideration.*

18                    *“(ii) EXPEDITED HEARING.—In a*  
19          *hearing by the Secretary under this section,*  
20          *in which the moving party alleges that no*  
21          *material issues of fact are in dispute, the*  
22          *Secretary shall make an expedited deter-*  
23          *mination as to whether any such facts are*  
24          *in dispute and, if not, shall render a deci-*  
25          *sion expeditiously.*

1           “(G) *REOPENING AND REVISION OF DETER-*  
 2           *MINATIONS.—The Secretary may reopen or revise*  
 3           *any initial determination or reconsidered deter-*  
 4           *mination described in this subsection under*  
 5           *guidelines established by the Secretary in regula-*  
 6           *tions.*

7           “(2) *REVIEW OF COVERAGE DETERMINATIONS.—*

8           “(A) *NATIONAL COVERAGE DETERMINA-*  
 9           *TIONS.—*

10           “(i) *IN GENERAL.—Review of any na-*  
 11           *tional coverage determination shall be sub-*  
 12           *ject to the following limitations:*

13                   “(I) *Such a determination shall*  
 14                   *not be reviewed by any administrative*  
 15                   *law judge.*

16                   “(II) *Such a determination shall*  
 17                   *not be held unlawful or set aside on the*  
 18                   *ground that a requirement of section*  
 19                   *553 of title 5, United States Code, or*  
 20                   *section 1871(b) of this title, relating to*  
 21                   *publication in the Federal Register or*  
 22                   *opportunity for public comment, was*  
 23                   *not satisfied.*

24                   “(III) *Upon the filing of a com-*  
 25                   *plaint by an aggrieved party, such a*

1                   *determination shall be reviewed by the*  
2                   *Departmental Appeals Board of the*  
3                   *Department of Health and Human*  
4                   *Services. In conducting such a review,*  
5                   *the Departmental Appeals Board shall*  
6                   *review the record and shall permit dis-*  
7                   *covery and the taking of evidence to*  
8                   *evaluate the reasonableness of the deter-*  
9                   *mination. In reviewing such a deter-*  
10                  *mination, the Departmental Appeals*  
11                  *Board shall defer only to the reason-*  
12                  *able findings of fact, reasonable inter-*  
13                  *pretations of law, and reasonable ap-*  
14                  *plications of fact to law by the Sec-*  
15                  *retary.*

16                  “(IV) *A decision of the Depart-*  
17                  *mental Appeals Board constitutes a*  
18                  *final agency action and is subject to*  
19                  *judicial review.*

20                  “(ii) *DEFINITION OF NATIONAL COV-*  
21                  *ERAGE DETERMINATION.—For purposes of*  
22                  *this section, the term ‘national coverage de-*  
23                  *termination’ means a determination by the*  
24                  *Secretary respecting whether or not a par-*  
25                  *ticular item or service is covered nationally*

1                   under this title, including such a deter-  
2                   mination under 1862(a)(1).

3                   “(B) *LOCAL COVERAGE DETERMINATION.*—In the  
4                   case of a local coverage determination made by a fis-  
5                   cal intermediary or a carrier under part A or part  
6                   B respecting whether a particular type or class of  
7                   items or services is covered under such parts, the fol-  
8                   lowing limitations apply:

9                   “(i) Upon the filing of a complaint by an  
10                  aggrieved party, such a determination shall be  
11                  reviewed by an administrative law judge of the  
12                  Social Security Administration. The administra-  
13                  tive law judge shall review the record and shall  
14                  permit discovery and the taking of evidence to  
15                  evaluate the reasonableness of the determination.  
16                  In reviewing such a determination, the adminis-  
17                  trative law judge shall defer only to the reason-  
18                  able findings of fact, reasonable interpretations  
19                  of law, and reasonable applications of fact to law  
20                  by the Secretary.

21                  “(ii) Such a determination may be reviewed  
22                  by the Departmental Appeals Board of the De-  
23                  partment of Health and Human Services.

1           “(iii) *A decision of the Departmental Ap-*  
2           *peals Board constitutes a final agency action*  
3           *and is subject to judicial review.*

4           “(C) *NO MATERIAL ISSUES OF FACT IN DIS-*  
5           *PUTE.—In the case of review of a determination*  
6           *under subparagraph (A)(i)(III) or (B)(i) where the*  
7           *moving party alleges that there are no material issues*  
8           *of fact in dispute, and alleges that the only issue is*  
9           *the constitutionality of a provision of this title, or*  
10          *that a regulation, determination, or ruling by the*  
11          *Secretary is invalid, the moving party may seek re-*  
12          *view by a court of competent jurisdiction.*

13          “(D) *PENDING NATIONAL COVERAGE DETERMINA-*  
14          *TIONS.—*

15          “(i) *IN GENERAL.—In the event the Sec-*  
16          *retary has not issued a national coverage or non-*  
17          *coverage determination with respect to a par-*  
18          *ticular type or class of items or services, an af-*  
19          *ected party may submit to the Secretary a re-*  
20          *quest to make such a determination with respect*  
21          *to such items or services. By not later than the*  
22          *end of the 90-day period beginning on the date*  
23          *the Secretary receives such a request, the Sec-*  
24          *retary shall take one of the following actions:*

1           “(I) Issue a national coverage deter-  
2           mination, with or without limitations.

3           “(II) Issue a national noncoverage de-  
4           termination.

5           “(III) Issue a determination that no  
6           national coverage or noncoverage deter-  
7           mination is appropriate as of the end of  
8           such 90-day period with respect to national  
9           coverage of such items or services.

10          “(IV) Issue a notice that states that the  
11          Secretary has not completed a review of the  
12          request for a national coverage determina-  
13          tion and that includes an identification of  
14          the remaining steps in the Secretary’s re-  
15          view process and a deadline by which the  
16          Secretary will complete the review and take  
17          an action described in subclause (I), (II), or  
18          (III).

19          “(ii) In the case of an action described in  
20          clause (i)(IV), if the Secretary fails to take an  
21          action referred to in such clause by the deadline  
22          specified by the Secretary under such clause,  
23          then the Secretary is deemed to have taken an  
24          action described in clause (i)(III) as of the dead-  
25          line.

1           “(iii) When issuing a determination under  
2           clause (i), the Secretary shall include an expla-  
3           nation of the basis for the determination. An ac-  
4           tion taken under clause (i) (other than subclause  
5           (IV)) is deemed to be a national coverage deter-  
6           mination for purposes of review under subpara-  
7           graph (A).

8           “(E) ANNUAL REPORT ON NATIONAL COVERAGE  
9           DETERMINATIONS.—

10           “(i) IN GENERAL.—Not later than December  
11           1 of each year, beginning in 2001, the Secretary  
12           shall submit to Congress a report that sets forth  
13           a detailed compilation of the actual time periods  
14           that were necessary to complete and fully imple-  
15           ment national coverage determinations that were  
16           made in the previous fiscal year for items, serv-  
17           ices, or medical devices not previously covered as  
18           a benefit under this title, including, with respect  
19           to each new item, service, or medical device, a  
20           statement of the time taken by the Secretary to  
21           make the necessary coverage, coding, and pay-  
22           ment determinations, including the time taken to  
23           complete each significant step in the process of  
24           making such determinations.

1                   “(i) *PUBLICATION OF REPORTS ON THE*  
2                   *INTERNET.—The Secretary shall publish each re-*  
3                   *port submitted under clause (i) on the medicare*  
4                   *Internet site of the Department of Health and*  
5                   *Human Services.*

6                   “(3) *PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each deci-*  
7                   *sion of a hearing by the Secretary shall be made pub-*  
8                   *lic, and the Secretary shall publish each decision on*  
9                   *the Medicare Internet site of the Department of*  
10                  *Health and Human Services. The Secretary shall re-*  
11                  *move from such decision any information that would*  
12                  *identify any individual, provider of services, or sup-*  
13                  *plier.*

14                  “(4) *LIMITATION ON REVIEW OF CERTAIN REGU-*  
15                  *LATIONS.—A regulation or instruction which relates*  
16                  *to a method for determining the amount of payment*  
17                  *under part B and which was initially issued before*  
18                  *January 1, 1981, shall not be subject to judicial re-*  
19                  *view.*

20                  “(5) *STANDING.—An action under this section*  
21                  *seeking review of a coverage determination (with re-*  
22                  *spect to items and services under this title) may be*  
23                  *initiated only by one (or more) of the following ag-*  
24                  *grieved persons, or classes of persons:*  
25

1           “(A) *Individuals entitled to benefits under*  
 2           *part A, or enrolled under part B, or both, who*  
 3           *are in need of the items or services that are the*  
 4           *subject of the coverage determination.*

5           “(B) *Persons, or classes of persons, who*  
 6           *make, manufacture, offer, supply, make avail-*  
 7           *able, or provide such items and services.*

8           “(c) *CONDUCT OF RECONSIDERATIONS BY INDE-*  
 9           *PENDENT CONTRACTORS.—*

10           “(1) *IN GENERAL.—The Secretary shall enter*  
 11           *into contracts with qualified independent contractors*  
 12           *to conduct reconsiderations of initial determinations*  
 13           *made under paragraphs (2) and (3) of subsection (a).*  
 14           *Contracts shall be for an initial term of three years*  
 15           *and shall be renewable on a triennial basis thereafter.*

16           “(2) *QUALIFIED INDEPENDENT CONTRACTOR.—*  
 17           *For purposes of this subsection, the term ‘qualified*  
 18           *independent contractor’ means an entity or organiza-*  
 19           *tion that is independent of any organization under*  
 20           *contract with the Secretary that makes initial deter-*  
 21           *minations under subsection (a), and that meets the*  
 22           *requirements established by the Secretary consistent*  
 23           *with paragraph (3).*

24           “(3) *REQUIREMENTS.—Any qualified inde-*  
 25           *pendent contractor entering into a contract with the*

1     *Secretary under this subsection shall meet the fol-*  
2     *lowing requirements:*

3             “(A) *IN GENERAL.*—*The qualified inde-*  
4             *pendent contractor shall perform such duties and*  
5             *functions and assume such responsibilities as*  
6             *may be required under regulations of the Sec-*  
7             *retary promulgated to carry out the provisions of*  
8             *this subsection, and such additional duties, func-*  
9             *tions, and responsibilities as provided under the*  
10            *contract.*

11            “(B) *DETERMINATIONS.*—*The qualified*  
12            *independent contractor shall determine, on the*  
13            *basis of such criteria, guidelines, and policies es-*  
14            *tablished by the Secretary and published under*  
15            *subsection (d)(2)(D), whether payment shall be*  
16            *made for items or services under part A or part*  
17            *B and the amount of such payment. Such deter-*  
18            *mination shall constitute the conclusive deter-*  
19            *mination on those issues for purposes of payment*  
20            *under such parts for fiscal intermediaries, car-*  
21            *riers, and other entities whose determinations*  
22            *are subject to review by the contractor; except*  
23            *that payment may be made if—*

24                    “(i) *such payment is allowed by reason*  
25                    *of section 1879;*

1           “(ii) *in the case of inpatient hospital*  
2           *services or extended care services, the quali-*  
3           *fied independent contractor determines that*  
4           *additional time is required in order to ar-*  
5           *range for postdischarge care, but payment*  
6           *may be continued under this clause for not*  
7           *more than 2 days, and only in the case in*  
8           *which the provider of such services did not*  
9           *know and could not reasonably have been*  
10           *expected to know (as determined under sec-*  
11           *tion 1879) that payment would not other-*  
12           *wise be made for such services under part A*  
13           *or part B prior to notification by the quali-*  
14           *fied independent contractor under this sub-*  
15           *section;*

16           “(iii) *such determination is changed as*  
17           *the result of any hearing by the Secretary*  
18           *or judicial review of the decision under this*  
19           *section; or*

20           “(iv) *such payment is authorized*  
21           *under section 1861(v)(1)(G).*

22           “(C) *DEADLINES FOR DECISIONS.—*

23           “(i) *DETERMINATIONS.—The qualified*  
24           *independent contractor shall conduct and*  
25           *conclude a determination under subpara-*

1 *graph (B) or an appeal of an initial deter-*  
2 *mination, and mail the notice of the deci-*  
3 *sion by not later than the end of the 45-day*  
4 *period beginning on the date a request for*  
5 *reconsideration has been timely filed.*

6 “(ii) *CONSEQUENCES OF FAILURE TO*  
7 *MEET DEADLINE.*—*In the case of a failure*  
8 *by the qualified independent contractor to*  
9 *mail the notice of the decision by the end of*  
10 *the period described in clause (i), the party*  
11 *requesting the reconsideration or appeal*  
12 *may request a hearing before an adminis-*  
13 *trative law judge, notwithstanding any re-*  
14 *quirements for a reconsidered determination*  
15 *for purposes of the party’s right to such*  
16 *hearing.*

17 “(iii) *EXPEDITED RECONSIDER-*  
18 *ATIONS.*—*The qualified independent con-*  
19 *tractor shall perform an expedited reconsid-*  
20 *eration under subsection (b)(1)(F) of a no-*  
21 *tice from a provider of services or supplier*  
22 *that payment may not be made for an item*  
23 *or service furnished by the provider of serv-*  
24 *ices or supplier, of a decision by a provider*  
25 *of services to terminate services furnished to*

1           *an individual, or in accordance with the*  
2           *following:*

3                     “(I) *DEADLINE FOR DECISION.*—

4                     *Notwithstanding section 216(j), not*  
5                     *later than 1 day after the date the*  
6                     *qualified independent contractor has*  
7                     *received a request for such reconsider-*  
8                     *ation and has received such medical or*  
9                     *other records needed for such reconsid-*  
10                    *eration, the qualified independent con-*  
11                    *tractor shall provide notice (by tele-*  
12                    *phone and in writing) to the indi-*  
13                    *vidual and the provider of services and*  
14                    *attending physician of the individual*  
15                    *of the results of the reconsideration.*  
16                    *Such reconsideration shall be con-*  
17                    *ducted regardless of whether the pro-*  
18                    *vider of services or supplier will charge*  
19                    *the individual for continued services or*  
20                    *whether the individual will be liable*  
21                    *for payment for such continued serv-*  
22                    *ices.*

23                    “(II) *CONSULTATION WITH BENE-*

24                    *FICIARY.*—*In such reconsideration, the*  
25                    *qualified independent contractor shall*

1                   *solicit the views of the individual in-*  
2                   *volved.*

3                   “(D) *LIMITATION ON INDIVIDUAL REVIEW-*  
4                   *ING DETERMINATIONS.—*

5                   “(i) *PHYSICIANS.—No physician under*  
6                   *the employ of a qualified independent con-*  
7                   *tractor may review—*

8                   “(I) *determinations regarding*  
9                   *health care services furnished to a pa-*  
10                  *tient if the physician was directly re-*  
11                  *sponsible for furnishing such services;*  
12                  *or*

13                  “(II) *determinations regarding*  
14                  *health care services provided in or by*  
15                  *an institution, organization, or agen-*  
16                  *cy, if the physician or any member of*  
17                  *the physician’s family has, directly or*  
18                  *indirectly, a significant financial in-*  
19                  *terest in such institution, organization,*  
20                  *or agency.*

21                  “(ii) *PHYSICIAN’S FAMILY DE-*  
22                  *SCRIBED.—For purposes of this paragraph,*  
23                  *a physician’s family includes the physi-*  
24                  *cian’s spouse (other than a spouse who is le-*  
25                  *gally separated from the physician under a*

1           *decree of divorce or separate maintenance),*  
2           *children (including stepchildren and legally*  
3           *adopted children), grandchildren, parents,*  
4           *and grandparents.*

5           “(E) *EXPLANATION OF DETERMINATIONS.—*

6           *Any determination of a qualified independent*  
7           *contractor shall be in writing, and shall include*  
8           *a detailed explanation of the determination as*  
9           *well as a discussion of the pertinent facts and*  
10           *applicable regulations applied in making such*  
11           *determination.*

12           “(F) *NOTICE REQUIREMENTS.—Whenever a*

13           *qualified independent contractor makes a deter-*  
14           *mination under this subsection, the qualified*  
15           *independent contractor shall promptly notify*  
16           *such individual and the entity responsible for the*  
17           *payment of claims under part A or part B of*  
18           *such determination.*

19           “(G) *DISSEMINATION OF INFORMATION.—*

20           *Each qualified independent contractor shall,*  
21           *using the methodology established by the Sec-*  
22           *retary under subsection (d)(4), make available*  
23           *all determinations of such qualified independent*  
24           *contractors to fiscal intermediaries (under sec-*  
25           *tion 1816), carriers (under section 1842), peer*

1        *review organizations (under part B of title XI),*  
 2        *Medicare+Choice organizations offering*  
 3        *Medicare+Choice plans under part C, and other*  
 4        *entities under contract with the Secretary to*  
 5        *make initial determinations under part A or*  
 6        *part B or title XI.*

7                *“(H) ENSURING CONSISTENCY IN DETER-*  
 8        *MINATIONS.—Each qualified independent con-*  
 9        *tractor shall monitor its determinations to en-*  
 10        *sure the consistency of its determinations with*  
 11        *respect to requests for reconsideration of similar*  
 12        *or related matters.*

13                *“(I) DATA COLLECTION.—*

14                *“(i) IN GENERAL.—Consistent with the*  
 15        *requirements of clause (ii), a qualified inde-*  
 16        *pendent contractor shall collect such infor-*  
 17        *mation relevant to its functions, and keep*  
 18        *and maintain such records in such form*  
 19        *and manner as the Secretary may require*  
 20        *to carry out the purposes of this section and*  
 21        *shall permit access to and use of any such*  
 22        *information and records as the Secretary*  
 23        *may require for such purposes.*

24                *“(ii) TYPE OF DATA COLLECTED.—*  
 25        *Each qualified independent contractor shall*

1           *keep accurate records of each decision made,*  
2           *consistent with standards established by the*  
3           *Secretary for such purpose. Such records*  
4           *shall be maintained in an electronic data-*  
5           *base in a manner that provides for identi-*  
6           *fication of the following:*

7                     “(I) *Specific claims that give rise*  
8                     *to appeals.*

9                     “(II) *Situations suggesting the*  
10                    *need for increased education for pro-*  
11                    *viders of services, physicians, or sup-*  
12                    *pliers.*

13                    “(III) *Situations suggesting the*  
14                    *need for changes in national or local*  
15                    *coverage policy.*

16                    “(IV) *Situations suggesting the*  
17                    *need for changes in local medical re-*  
18                    *view policies.*

19                    “(iii) *ANNUAL REPORTING.—Each*  
20                    *qualified independent contractor shall sub-*  
21                    *mit annually to the Secretary (or otherwise*  
22                    *as the Secretary may request) records main-*  
23                    *tained under this paragraph for the pre-*  
24                    *vious year.*

1           “(J) *HEARINGS BY THE SECRETARY.*—The  
2           *qualified independent contractor shall (i) pre-*  
3           *pare such information as is required for an ap-*  
4           *peal of its reconsidered determination to the Sec-*  
5           *retary for a hearing, including as necessary, ex-*  
6           *planations of issues involved in the determina-*  
7           *tion and relevant policies, and (ii) participate*  
8           *in such hearings as required by the Secretary.*

9           “(4) *NUMBER OF QUALIFIED INDEPENDENT CON-*  
10          *TRACTORS.*—The Secretary shall enter into contracts  
11          *with not fewer than 12 qualified independent contrac-*  
12          *tors under this subsection.*

13          “(5) *LIMITATION ON QUALIFIED INDEPENDENT*  
14          *CONTRACTOR LIABILITY.*—No qualified independent  
15          *contractor having a contract with the Secretary under*  
16          *this subsection and no person who is employed by, or*  
17          *who has a fiduciary relationship with, any such*  
18          *qualified independent contractor or who furnishes*  
19          *professional services to such qualified independent*  
20          *contractor, shall be held by reason of the performance*  
21          *of any duty, function, or activity required or author-*  
22          *ized pursuant to this subsection or to a valid contract*  
23          *entered into under this subsection, to have violated*  
24          *any criminal law, or to be civilly liable under any*  
25          *law of the United States or of any State (or political*

1       subdivision thereof) provided due care was exercised  
 2       in the performance of such duty, function, or activity.

3       “(d) *ADMINISTRATIVE PROVISIONS.*—

4               “(1) *OUTREACH.*—The Secretary shall perform  
 5       such outreach activities as are necessary to inform in-  
 6       dividuals entitled to benefits under this title and pro-  
 7       viders of services and suppliers with respect to their  
 8       rights of, and the process for, appeals made under this  
 9       section. The Secretary shall use the toll-free telephone  
 10       number maintained by the Secretary (1-800-  
 11       MEDICAR(E)) (1-800-633-4227) to provide infor-  
 12       mation regarding appeal rights and respond to in-  
 13       quiries regarding the status of appeals.

14              “(2) *GUIDANCE FOR RECONSIDERATIONS AND*  
 15       *HEARINGS.*—

16              “(A) *REGULATIONS.*—Not later than 1 year  
 17       after the date of the enactment of this section, the  
 18       Secretary shall promulgate regulations governing  
 19       the processes of reconsiderations of determina-  
 20       tions by the Secretary and qualified independent  
 21       contractors and of hearings by the Secretary.  
 22       Such regulations shall include such specific cri-  
 23       teria and provide such guidance as required to  
 24       ensure the adequate functioning of the reconsid-

1           *erations and hearings processes and to ensure*  
 2           *consistency in such processes.*

3                   “(B) *DEADLINES FOR ADMINISTRATIVE AC-*  
 4           *TION.—*

5                           “(i) *HEARING BY ADMINISTRATIVE LAW*  
 6           *JUDGE.—*

7                                   “(II) *IN GENERAL.—Except as*  
 8                           *provided in subclause (II), an admin-*  
 9                           *istrative law judge shall conduct and*  
 10                           *conclude a hearing on a decision of a*  
 11                           *qualified independent contractor under*  
 12                           *subsection (c) and render a decision on*  
 13                           *such hearing by not later than the end*  
 14                           *of the 90-day period beginning on the*  
 15                           *date a request for hearing has been*  
 16                           *timely filed.*

17                                   “(II) *WAIVER OF DEADLINE BY*  
 18                           *PARTY SEEKING HEARING.—The 90-*  
 19                           *day period under subclause (i) shall*  
 20                           *not apply in the case of a motion or*  
 21                           *stipulation by the party requesting the*  
 22                           *hearing to waive such period.*

23                                   “(ii) *DEPARTMENTAL APPEALS BOARD*  
 24                           *REVIEW.—The Departmental Appeals Board*  
 25                           *of the Department of Health and Human*

1           *Services shall conduct and conclude a re-*  
2           *view of the decision on a hearing described*  
3           *in subparagraph (B) and make a decision*  
4           *or remand the case to the administrative*  
5           *law judge for reconsideration by not later*  
6           *than the end of the 90-day period beginning*  
7           *on the date a request for review has been*  
8           *timely filed.*

9           “(iii) *CONSEQUENCES OF FAILURE TO*  
10          *MEET DEADLINES.—In the case of a failure*  
11          *by an administrative law judge to render a*  
12          *decision by the end of the period described*  
13          *in clause (ii), the party requesting the hear-*  
14          *ing may request a review by the Depart-*  
15          *mental Appeals Board of the Department of*  
16          *Health and Human Services, notwith-*  
17          *standing any requirements for a hearing for*  
18          *purposes of the party’s right to such a re-*  
19          *view.*

20          “(iv) *DAB HEARING PROCEDURE.—In*  
21          *the case of a request described in clause*  
22          *(iii), the Departmental Appeals Board shall*  
23          *review the case de novo.*

24          “(C) *POLICIES.—The Secretary shall pro-*  
25          *vide such specific criteria and guidance, includ-*

ing all applicable national and local coverage policies and rationale for such policies, as is necessary to assist the qualified independent contractors to make informed decisions in considering appeals under this section. The Secretary shall furnish to the qualified independent contractors the criteria and guidance described in this paragraph in a published format, which may be an electronic format.

“(D) *PUBLICATION OF MEDICARE COVERAGE POLICIES ON THE INTERNET.*—The Secretary shall publish national and local coverage policies under this title on an Internet site maintained by the Secretary.

“(E) *EFFECT OF FAILURE TO PUBLISH POLICIES.*—

“(i) *NATIONAL AND LOCAL COVERAGE POLICIES.*—Qualified independent contractors shall not be bound by any national or local medicare coverage policy established by the Secretary that is not published on the Internet site under subparagraph (D).

“(ii) *OTHER POLICIES.*—With respect to policies established by the Secretary other than the policies described in clause (i),

1           *qualified independent contractors shall not*  
2           *be bound by such policies if the Secretary*  
3           *does not furnish to the qualified inde-*  
4           *pendent contractor the policies in a pub-*  
5           *lished format consistent with subparagraph*  
6           *(C).*

7           “(3) *CONTINUING EDUCATION REQUIREMENT FOR*  
8           *QUALIFIED INDEPENDENT CONTRACTORS AND ADMIN-*  
9           *ISTRATIVE LAW JUDGES.*—

10           “(A) *IN GENERAL.*—*The Secretary shall*  
11           *provide to each qualified independent contractor,*  
12           *and, in consultation with the Commissioner of*  
13           *Social Security, to administrative law judges*  
14           *that decide appeals of reconsiderations of initial*  
15           *determinations or other decisions or determina-*  
16           *tions under this section, such continuing edu-*  
17           *cation with respect to policies of the Secretary*  
18           *under this title or part B of title XI as is nec-*  
19           *essary for such qualified independent contractors*  
20           *and administrative law judges to make informed*  
21           *decisions with respect to appeals.*

22           “(B) *MONITORING OF DECISIONS BY QUALI-*  
23           *FIED INDEPENDENT CONTRACTORS AND ADMINIS-*  
24           *TRATIVE LAW JUDGES.*—*The Secretary shall*  
25           *monitor determinations made by all qualified*

1           *independent contractors and administrative law*  
2           *judges under this section and shall provide con-*  
3           *tinuing education and training to such qualified*  
4           *independent contractors and administrative law*  
5           *judges to ensure consistency of determinations*  
6           *with respect to appeals on similar or related*  
7           *matters. To ensure such consistency, the Sec-*  
8           *retary shall provide for administration and over-*  
9           *sight of qualified independent contractors and,*  
10          *in consultation with the Commissioner of Social*  
11          *Security, administrative law judges through a*  
12          *central office of the Department of Health and*  
13          *Human Services. Such administration and over-*  
14          *sight may not be delegated to regional offices of*  
15          *the Department.*

16           “(4) *DISSEMINATION OF DETERMINATIONS.*—*The*  
17          *Secretary shall establish a methodology under which*  
18          *qualified independent contractors shall carry out sub-*  
19          *section (c)(3)(G).*

20           “(5) *SURVEY.*—*Not less frequently than every 5*  
21          *years, the Secretary shall conduct a survey of a valid*  
22          *sample of individuals entitled to benefits under this*  
23          *title, providers of services, and suppliers to determine*  
24          *the satisfaction of such individuals or entities with*  
25          *the process for appeals of determinations provided for*

1        *under this section and education and training pro-*  
 2        *vided by the Secretary with respect to that process.*  
 3        *The Secretary shall submit to Congress a report de-*  
 4        *scribing the results of the survey, and shall include*  
 5        *any recommendations for administrative or legislative*  
 6        *actions that the Secretary determines appropriate.*

7            “(6) *REPORT TO CONGRESS.*—*The Secretary*  
 8        *shall submit to Congress an annual report describing*  
 9        *the number of appeals for the previous year, identi-*  
 10       *fying issues that require administrative or legislative*  
 11       *actions, and including any recommendations of the*  
 12       *Secretary with respect to such actions. The Secretary*  
 13       *shall include in such report an analysis of determina-*  
 14       *tions by qualified independent contractors with re-*  
 15       *spect to inconsistent decisions and an analysis of the*  
 16       *causes of any such inconsistencies.”.*

17        (b) *APPLICABILITY OF REQUIREMENTS AND LIMITA-*  
 18       *TIONS ON LIABILITY OF QUALIFIED INDEPENDENT CON-*  
 19       *TRACTORS TO MEDICARE+CHOICE INDEPENDENT APPEALS*  
 20       *CONTRACTORS.*—*Section 1852(g)(4) of the Social Security*  
 21       *Act (42 U.S.C. 1395w–22(e)(3)) is amended by adding at*  
 22       *the end the following: “The provisions of section 1869(c)(5)*  
 23       *shall apply to independent outside entities under contract*  
 24       *with the Secretary under this paragraph.”.*

1       (c) *CONFORMING AMENDMENT TO REVIEW BY THE*  
 2 *PROVIDER REIMBURSEMENT REVIEW BOARD.*—Section  
 3 1878(g) of the Social Security Act (42 U.S.C. 1395oo(g))  
 4 is amended by adding at the end the following new para-  
 5 graph:

6       “(3) Findings described in paragraph (1) and deter-  
 7 minations and other decisions described in paragraph (2)  
 8 may be reviewed or appealed under section 1869.”.

9       **SEC. 222. PROVISIONS WITH RESPECT TO LIMITATIONS ON**  
 10                               **LIABILITY OF BENEFICIARIES.**

11       (a) *EXPANSION OF LIMITATION OF LIABILITY PROTEC-*  
 12 *TION FOR BENEFICIARIES WITH RESPECT TO MEDICARE*  
 13 *CLAIMS NOT PAID OR PAID INCORRECTLY.*—

14               (1) *IN GENERAL.*—Section 1879 of the Social Se-  
 15 curity Act (42 U.S.C. 1395pp) is amended by adding  
 16 at the end the following new subsections:

17       “(i) Notwithstanding any other provision of this Act,  
 18 an individual who is entitled to benefits under this title  
 19 and is furnished a service or item is not liable for repay-  
 20 ment to the Secretary of amounts with respect to such  
 21 benefits—

22               “(1) subject to paragraph (2), in the case of a  
 23 claim for such item or service that is incorrectly paid  
 24 by the Secretary; and

1           “(2) in the case of payments made to the indi-  
2       vidual by the Secretary with respect to any claim  
3       under paragraph (1), the individual shall be liable for  
4       repayment of such amount only up to the amount of  
5       payment received by the individual from the Sec-  
6       retary.

7           “(j)(1) An individual who is entitled to benefits under  
8       this title and is furnished a service or item is not liable  
9       for payment of amounts with respect to such benefits in the  
10      following cases:

11           “(A) In the case of a benefit for which an initial  
12       determination has not been made by the Secretary  
13       under subsection (a) whether payment may be made  
14       under this title for such benefit.

15           “(B) In the case of a claim for such item or serv-  
16       ice that is—

17           “(i) improperly submitted by the provider  
18       of services or supplier; or

19           “(ii) rejected by an entity under contract  
20       with the Secretary to review or pay claims for  
21       services and items furnished under this title, in-  
22       cluding an entity under contract with the Sec-  
23       retary under section 1857.

24           “(2) The limitation on liability under paragraph (1)  
25       shall not apply if the individual signs a waiver provided

1 *by the Secretary under subsection (l) of protections under*  
2 *this paragraph, except that any such waiver shall not apply*  
3 *in the case of a denial of a claim for noncompliance with*  
4 *applicable regulations or procedures under this title or title*  
5 *XI.*

6       “(k) *An individual who is entitled to benefits under*  
7 *this title and is furnished services by a provider of services*  
8 *is not liable for payment of amounts with respect to such*  
9 *services prior to noon of the first working day after the date*  
10 *the individual receives the notice of determination to dis-*  
11 *charge and notice of appeal rights under paragraph (1),*  
12 *unless the following conditions are met:*

13               “(1) *The provider of services shall furnish a no-*  
14 *tice of discharge and appeal rights established by the*  
15 *Secretary under subsection (l) to each individual enti-*  
16 *tled to benefits under this title to whom such provider*  
17 *of services furnishes services, upon admission of the*  
18 *individual to the provider of services and upon notice*  
19 *of determination to discharge the individual from the*  
20 *provider of services, of the individual’s limitations of*  
21 *liability under this section and rights of appeal under*  
22 *section 1869.*

23               “(2) *If the individual, prior to discharge from*  
24 *the provider of services, appeals the determination to*  
25 *discharge under section 1869 not later than noon of*

1       *the first working day after the date the individual re-*  
2       *ceives the notice of determination to discharge and*  
3       *notice of appeal rights under paragraph (1), the pro-*  
4       *vider of services shall, by the close of business of such*  
5       *first working day, provide to the Secretary (or quali-*  
6       *fied independent contractor under section 1869, as de-*  
7       *termined by the Secretary) the records required to re-*  
8       *view the determination.*

9       “(l) *The Secretary shall develop appropriate standard*  
10      *forms for individuals entitled to benefits under this title to*  
11      *waive limitation of liability protections under subsection*  
12      *(j) and to receive notice of discharge and appeal rights*  
13      *under subsection (k). The forms developed by the Secretary*  
14      *under this subsection shall clearly and in plain language*  
15      *inform such individuals of their limitations on liability,*  
16      *their rights under section 1869(a) to obtain an initial deter-*  
17      *mination by the Secretary of whether payment may be*  
18      *made under part A or part B for such benefit, and their*  
19      *rights of appeal under section 1869(b), and shall inform*  
20      *such individuals that they may obtain further information*  
21      *or file an appeal of the determination by use of the toll-*  
22      *free telephone number (1-800-MEDICAR(E)) (1-800-633-*  
23      *4227) maintained by the Secretary. The forms developed by*  
24      *the Secretary under this subsection shall be the only manner*

1 *in which such individuals may waive such protections*  
 2 *under this title or title XI.*

3       “(m) *An individual who is entitled to benefits under*  
 4 *this title and is furnished an item or service is not liable*  
 5 *for payment of cost sharing amounts of more than \$50 with*  
 6 *respect to such benefits unless the individual has been in-*  
 7 *formed in advance of being furnished the item or service*  
 8 *of the estimated amount of the cost sharing for the item*  
 9 *or service using a standard form established by the Sec-*  
 10 *retary.”.*

11           (2) *CONFORMING AMENDMENT.—Section 1870(a)*  
 12 *of the Social Security Act (42 U.S.C. 1395gg(a)) is*  
 13 *amended by striking “Any payment under this title”*  
 14 *and inserting “Except as provided in section 1879(i),*  
 15 *any payment under this title”.*

16       (b) *INCLUSION OF BENEFICIARY LIABILITY INFORMA-*  
 17 *TION IN EXPLANATION OF MEDICARE BENEFITS.—Section*  
 18 *1806(a) of the Social Security Act (42 U.S.C. 1395b–7(a))*  
 19 *is amended—*

20           (1) *in paragraph (1), by striking “and” at the*  
 21 *end;*

22           (2) *by redesignating paragraph (2) as para-*  
 23 *graph (3); and*

24           (3) *by inserting after paragraph (1) the fol-*  
 25 *lowing new paragraph:*

1           “(2) lists with respect to each item or service fur-  
 2           nished the amount of the individual’s liability for  
 3           payment;”;

4           (4) in paragraph (3), as so redesignated, by  
 5           striking the period at the end and inserting “; and”;  
 6           and

7           (5) by adding at the end the following new para-  
 8           graph:

9           “(4) includes the toll-free telephone number (1–  
 10          800–MEDICAR(E)) (1–800–633–4227) for informa-  
 11          tion and questions concerning the statement, liability  
 12          of the individual for payment, and appeal rights.”.

13 **SEC. 223. WAIVERS OF LIABILITY FOR COST SHARING**  
 14 **AMOUNTS.**

15          (a) *IN GENERAL.*—Section 1128A(i)(6)(A) of the So-  
 16          cial Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amend-  
 17          ed by striking clauses (i) through (iii) and inserting the  
 18          following:

19                       “(i) the waiver is offered as a part of  
 20                       a supplemental insurance policy or retiree  
 21                       health plan;

22                       “(ii) the waiver is not offered as part  
 23                       of any advertisement or solicitation, other  
 24                       than in conjunction with a policy or plan  
 25                       described in clause (i);

1           “(iii) the person waives the coinsur-  
 2           ance and deductible amount after the bene-  
 3           ficiary informs the person that payment of  
 4           the coinsurance or deductible amount would  
 5           pose a financial hardship for the indi-  
 6           vidual; or

7           “(iv) the person determines that the co-  
 8           insurance and deductible amount would not  
 9           justify the costs of collection.”.

10       (b) *CONFORMING AMENDMENT.*—Section 1128B(b) of  
 11       the Social Security Act (42 U.S.C. 1320a–7b(b)) is amend-  
 12       ed by adding at the end the following new paragraph:

13           “(4) In this section, the term ‘remuneration’ in-  
 14           cludes the meaning given such term in section  
 15           1128A(i)(6).”.

16       **SEC. 224. ELIMINATION OF MOTIONS BY THE SECRETARY**  
 17                               **ON DECISIONS OF THE PROVIDER REIM-**  
 18                               **BURSEMENT REVIEW BOARD.**

19       Section 1878(f)(1) of such Act (42 U.S.C. 1395oo(f)(1))  
 20       is amended—

21           (1) in the first sentence, by striking “unless the  
 22           Secretary, on his own motion, and within 60 days  
 23           after the provider of services is notified of the Board’s  
 24           decision, reverses, affirms, or modifies the Board’s de-  
 25           cision”;

1           (2) *in the second sentence, by striking “, or of*  
 2           *any reversal, affirmance, or modification by the Sec-*  
 3           *retary,” and “or of any reversal, affirmance, or modi-*  
 4           *fication by the Secretary”; and*

5           (3) *in the fifth sentence, by striking “and not*  
 6           *subject to review by the Secretary”.*

7   ***TITLE       III—MEDICARE+CHOICE***  
 8       ***REFORMS; PRESERVATION OF***  
 9       ***MEDICARE PART B DRUG BEN-***  
 10       ***EFIT***

11       ***Subtitle A—Medicare+Choice***  
 12               ***Reforms***

13   ***SEC.   301.   INCREASE   IN   NATIONAL   PER   CAPITA***  
 14               ***MEDICARE+CHOICE GROWTH PERCENTAGE IN***  
 15               ***2001 AND 2002.***

16       *Section 1853(c)(6)(B) of the Social Security Act (42*  
 17       *U.S.C. 1395w–23(c)(6)(B)) is amended—*

18           (1) *in clause (iv), by striking “for 2001, 0.5 per-*  
 19           *centage points” and inserting “for 2001, 0 percentage*  
 20           *points”; and*

21           (2) *in clause (v), by striking “for 2002, 0.3 per-*  
 22           *centage points” and inserting “for 2002, 0 percentage*  
 23           *points”.*

1 **SEC. 302. PERMANENTLY REMOVING APPLICATION OF**  
 2 **BUDGET NEUTRALITY BEGINNING IN 2002.**

3 *Section 1853(c) of the Social Security Act (42 U.S.C.*  
 4 *1395w-23(c)) is amended—*

5 *(1) in paragraph (1)(A), in the matter following*  
 6 *clause (ii), by inserting “(for years before 2002)”*  
 7 *after “multiplied”; and*

8 *(2) in paragraph (5), by inserting “(before*  
 9 *2002)” after “for each year”.*

10 **SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.**

11 *(a) IN GENERAL.—Section 1853(c)(1)(B)(ii) of the So-*  
 12 *cial Security Act (42 U.S.C. 1395w-23(c)(1)(B)(ii)) is*  
 13 *amended—*

14 *(1) by striking “(ii) For a succeeding year” and*  
 15 *inserting “(ii)(I) Subject to subclause (II), for a suc-*  
 16 *ceeding year”; and*

17 *(2) by adding at the end the following new sub-*  
 18 *clause:*

19 *“(II) For 2002 for any of the 50 States*  
 20 *and the District of Columbia, \$450.”.*

21 *(b) EFFECTIVE DATE.—The amendments made by sub-*  
 22 *section (a) apply to years beginning with 2002.*

23 **SEC. 304. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND**  
 24 **IN 2002.**

25 *Section 1853(c)(2) of the Social Security Act (42*  
 26 *U.S.C. 1395w-23(c)(2)) is amended—*

1           (1) by striking the period at the end of subpara-  
2           graph (F) and inserting a semicolon; and

3           (2) by adding after and below subparagraph (F)  
4           the following:

5           “except that a Medicare+Choice organization may  
6           elect to apply subparagraph (F) (rather than sub-  
7           paragraph (E)) for 2002.”.

8   **SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH**  
9                           **ONLY ONE OR NO MEDICARE+CHOICE CON-**  
10                          **TRACTS.**

11           (a) *IN GENERAL*.—Section 1853(c)(1)(C)(ii) of the So-  
12           cial Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is  
13           amended—

14                   (1) by striking “(ii) For a subsequent year” and  
15                   inserting “(ii)(I) Subject to subclause (II), for a sub-  
16                   sequent year”; and

17                   (2) by adding at the end the following new sub-  
18                   clause:

19                           “(II) During 2002, 2003, 2004, and  
20                           2005, in the case of a Medicare+Choice  
21                           payment area in which there is no more  
22                           than 1 contract entered into under this part  
23                           as of July 1 before the beginning of the  
24                           year, 102.5 percent of the annual  
25                           Medicare+Choice capitation rate under this

1                   paragraph for the area for the previous  
2                   year.”.

3           (b) *CONSTRUCTION.*—*The amendments made by sub-*  
4 *section (a) do not affect the payment of a first time bonus*  
5 *under section 1853(i) of the Social Security Act (42 U.S.C.*  
6 *1395w–23(i)).*

7   ***SEC. 306. PERMITTING HIGHER NEGOTIATED RATES IN CER-***  
8                   ***TAIN MEDICARE+CHOICE PAYMENT AREAS***  
9                   ***BELOW NATIONAL AVERAGE.***

10          *Section 1853(c)(1) of the Social Security Act (42*  
11 *U.S.C. 1395w–23(c)(1)) is amended—*

12                   (1) *in the matter before subparagraph (A), by*  
13 *striking “or (C)” and inserting “(C), or (D)”;* and

14                   (2) *by adding at the end the following new sub-*  
15 *paragraph:*

16                               ***“(D) PERMITTING HIGHER RATES THROUGH***  
17 ***NEGOTIATION.—***

18                               ***“(i) IN GENERAL.—For each year be-***  
19 *ginning with 2004, in the case of a*  
20 *Medicare+Choice payment area for which*  
21 *the Medicare+Choice capitation rate under*  
22 *this paragraph would otherwise be less than*  
23 *the United States per capita cost (USPCC),*  
24 *as calculated by the Secretary, a*  
25 *Medicare+Choice organization may nego-*

1           *tiate with the Medicare Benefits Adminis-*  
2           *trator an annual per capita rate that—*

3                     *“(I) reflects an annual rate of in-*  
4                     *crease up to the rate of increase speci-*  
5                     *fied in clause (ii);*

6                     *“(II) takes into account audited*  
7                     *current data supplied by the organiza-*  
8                     *tion on its adjusted community rate*  
9                     *(as defined in section 1854(f)(3)); and*

10                    *“(III) does not exceed the United*  
11                    *States per capita cost, as projected by*  
12                    *the Secretary for the year involved.*

13                    *“(ii) MAXIMUM RATE DESCRIBED.—*  
14                    *The rate of increase specified in this clause*  
15                    *for a year is the rate of inflation in private*  
16                    *health insurance for the year involved, as*  
17                    *projected by the Medicare Benefits Adminis-*  
18                    *trator, and includes such adjustments as*  
19                    *may be necessary—*

20                    *“(I) to reflect the demographic*  
21                    *characteristics in the population under*  
22                    *this title; and*

23                    *“(II) to eliminate the costs of pre-*  
24                    *scription drugs.*

1                   “(iii) *ADJUSTMENTS FOR OVER OR*  
 2                   *UNDER PROJECTIONS.—If subparagraph is*  
 3                   *applied to an organization and payment*  
 4                   *area for a year, in applying this subpara-*  
 5                   *graph for a subsequent year the provisions*  
 6                   *of paragraph (6)(C) shall apply in the same*  
 7                   *manner as such provisions apply under this*  
 8                   *paragraph.”.*

9   **SEC. 307. 10-YEAR PHASE IN OF RISK ADJUSTMENT BASED**  
 10                   **ON DATA FROM ALL SETTINGS.**

11           *Section 1853(a)(3)(C)(ii) of the Social Security Act*  
 12   *(42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—*

13                   *(1) by striking the period at the end of subclause*  
 14                   *(II) and inserting a semicolon; and*

15                   *(2) by adding after and below subclause (II) the*  
 16                   *following:*

17                   *“and, beginning in 2004, insofar as such*  
 18                   *risk adjustment is based on data from all*  
 19                   *settings, the methodology shall be phased in*  
 20                   *equal increments over a 10 year period, be-*  
 21                   *ginning with 2004 or (if later) the first*  
 22                   *year in which such data is used.”.*

1 ***Subtitle B—Preservation of Medi-***  
 2 ***care Coverage of Drugs and***  
 3 ***Biologicals***

4 ***SEC. 311. PRESERVATION OF COVERAGE OF DRUGS AND***  
 5 ***BIOLOGICALS UNDER PART B OF THE MEDI-***  
 6 ***CARE PROGRAM.***

7 (a) *IN GENERAL.*—Section 1861(s)(2) of the Social Se-  
 8 curity Act (42 U.S.C. 1395x(s)(2)) is amended, in each of  
 9 subparagraphs (A) and (B), by striking “(including drugs  
 10 and biologicals which cannot, as determined in accordance  
 11 with regulations, be self-administered)” and inserting “(in-  
 12 cluding injectable and infusable drugs and biologicals which  
 13 are not usually self-administered by the patient)”.

14 (b) *EFFECTIVE DATE.*—The amendment made by sub-  
 15 section (a) applies to drugs and biologicals administered  
 16 on or after October 1, 2000.

17 ***SEC. 312. GAO REPORT ON PART B PAYMENT FOR DRUGS***  
 18 ***AND BIOLOGICALS AND RELATED SERVICES.***

19 (a) *IN GENERAL.*—The Comptroller General of the  
 20 United States shall conduct a study to quantify the extent  
 21 to which reimbursement for drugs and biologicals under the  
 22 current medicare payment methodology (provided under  
 23 section 1842 (o) of the Social Security Act (42 U.S.C.  
 24 1395u(o)) overpays for the cost of such drugs and biologicals

1 compared to the average acquisition cost paid by physicians  
 2 or other suppliers of such drugs

3 (B) *ELEMENTS.*—The study shall also assess the con-  
 4 sequences of changing the current medicare payment meth-  
 5 odology to a payment methodology that is based on the aver-  
 6 age acquisition cost of the drugs. The study shall, at a min-  
 7 imum, assess the effects of such a reduction on—

8 (1) the delivery of health care services to Medi-  
 9 care beneficiaries with cancer;

10 (2) total Medicare expenditures, including an es-  
 11 timate of the number of patients who would, as a re-  
 12 sult of the payment reduction, receive chemotherapy  
 13 in a hospital rather than in a physician's office;

14 (3) the delivery of dialysis services;

15 (4) the delivery of vaccines;

16 (5) the administration in physician offices of  
 17 drugs other than cancer therapy drugs; and

18 (6) the effect on the delivery of drug therapies by  
 19 hospital outpatient departments of changing the aver-  
 20 age wholesale price as the basis for Medicare pass-  
 21 through payments to such departments, as included  
 22 in the Medicare, Medicaid, and SCHIP Balanced  
 23 Budget Refinement Act of 1999.

24 (c) *PAYMENT FOR RELATED PROFESSIONAL SERV-*  
 25 *ICES.*—The study shall also include a review of the extent

1 *to which other payment methodologies under part B of the*  
 2 *medicare program, if any, intended to reimburse physician*  
 3 *and other suppliers of drugs and biologicals described in*  
 4 *subsection (a) for costs incurred in handling, storing and*  
 5 *administering such drugs and biologicals are inadequate to*  
 6 *cover such costs and whether an additional payment would*  
 7 *be required to cover these costs under the average acquisi-*  
 8 *tion cost methodology.*

9 *(d) CONSIDERATION OF ISSUES IN IMPLEMENTING AN*  
 10 *AVERAGE ACQUISITION COST METHODOLOGY.—The study*  
 11 *shall assess possible means by which a payment method*  
 12 *based on average acquisition cost could be implemented, in-*  
 13 *cluding at least the following:*

14 *(1) Identification of possible bases for deter-*  
 15 *mining the average acquisition cost of drugs, such as*  
 16 *surveys of wholesaler catalog prices, and determina-*  
 17 *tion of the advantages, disadvantages, and costs (to*  
 18 *the government and public) of each possible approach.*

19 *(2) The impact on individual providers and*  
 20 *practitioners if average or median prices are used as*  
 21 *the payment basis.*

22 *(3) Methods for updating and keeping current*  
 23 *the prices used as the payment basis.*

24 *(e) COORDINATION WITH BBRA STUDY.—The Comp-*  
 25 *troller General shall conduct the study under this section*

1 *in coordination with the study provided for under section*  
2 *213(a) of the Medicare, Medicaid, and SCHIP Balanced*  
3 *Budget Refinement Act of 1999 (113 Stat. 1501A-350), as*  
4 *enacted into law by section 1000(a)(6) of Public Law 106-*  
5 *113.*

6       (f) *REPORT.*—*Not later than 6 months after the date*  
7 *of the enactment of this Act, the Comptroller General shall*  
8 *submit a report on the study conducted under this section,*  
9 *as well as the study referred to in subsection (e). Such re-*  
10 *port shall include recommendations regarding such changes*  
11 *in the medicare reimbursement policies described in sub-*  
12 *sections (a) and (c) as the Comptroller General deems ap-*  
13 *propriate, as well as the recommendations described in sec-*  
14 *tion 213(b) of the Medicare, Medicaid, and SCHIP Bal-*  
15 *anced Budget Refinement Act of 1999.*



**Union Calendar No. 396**

106TH CONGRESS  
2D SESSION

**H. R. 4680**

**[Report No. 106–703, Part I]**

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## **A BILL**

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes.

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*JUNE 27, 2000*

Reported from the Committee on Ways and Means with  
an amendment

*JUNE 27, 2000*

Referral to the Committee on Commerce extended for a  
period ending not later than June 27, 2000

*JUNE 27, 2000*

Committee on Commerce discharged; committed to the  
Committee of the Whole House on the State of the  
Union, and ordered to be printed